

67 6501

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 6501

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED V.
(Type or Print)

AMANDA BENDER (or BENDA)

2. DATE AND HOUR OF DEATH

July 3, 1967

5:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3528 Elmora Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2-20-83

9. AGE (In years last birthday)

84

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland - Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Gerhart

14. MOTHER'S MAIDEN NAME

Mary Seitz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

212

16. SOCIAL SECURITY NO.

36-9207

17. INFORMANT

BCH: Records 4940 Eastern Ave. Baltimore, Md.

ADDRESS #21224

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

Recurrent CVA

immediate

(B) DUE TO

Urinary tract infection 3 days

(C) DUE TO

CVA

3 yrs 3 mos.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

none

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 6, 1964 to July 3, 1967, that (I) (we) last saw the deceased alive on July 3, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Neil R. Williamson

M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

July 3, 1967

23C. PHYSICIAN'S NAME (Type)

Dr. Neil R. Williamson

M.D.

23D. ADDRESS

4940 Eastern Ave.

Baltimore, Maryland # 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/7/67

24C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 7 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

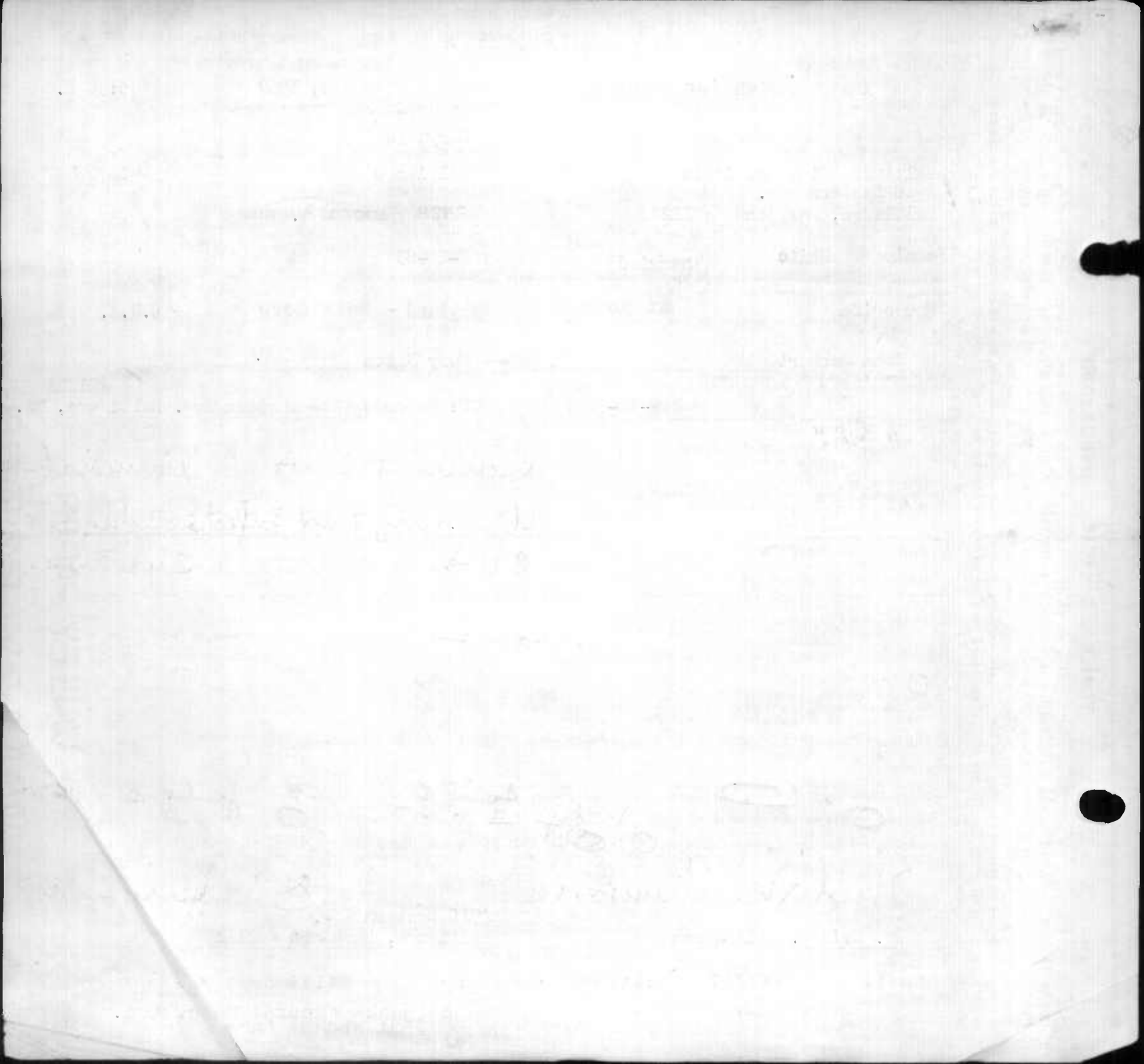
Schimunek Funeral Home, Inc.

3331 Brehms Lane

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6502

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 6502

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Herbert Walter Brazier Sr.

2. DATE AND HOUR OF DEATH

July 6, 1967

1:55 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

2706 Bayonne Ave

Baltimore Md 14

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2706 Bayonne Ave

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan 30, 1911

9. AGE (In years
last birthday)

56

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Balto, Police
City Dept.

11. BIRTHPLACE (State or foreign country)

Wash. D. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Leonard G. Brazier

14. MOTHER'S MAIDEN NAME

Hurley

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-03-1616

17. INFORMANT

Mrs. Nellie Brazier

ADDRESS

2706 Bayonne Ave

18. I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

(A) Metastatic carcinoma of 3 yrs.
DUE TO large bowel with colostomy
Multiple liver abscesses

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Jul. 64 & May 67 Carcinoma of lg. Bowel No

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 1960 19 to July 6, 1967 19
that (I) (we) last saw the deceased alive on May 6, 1967 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

7/7/67

23C. PHYSICIAN'S
NAME (Type)

Hans J. Koetter, M. D.

M.D.

23D. ADDRESS

5600 Harford Road

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/10/67

24C. NAME OF CEMETERY OR CREMATORY

Gardens Of Faith Cem

24D. LOCATION

Trumps Rd

(City, town, or county)

Balto Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 7 1967

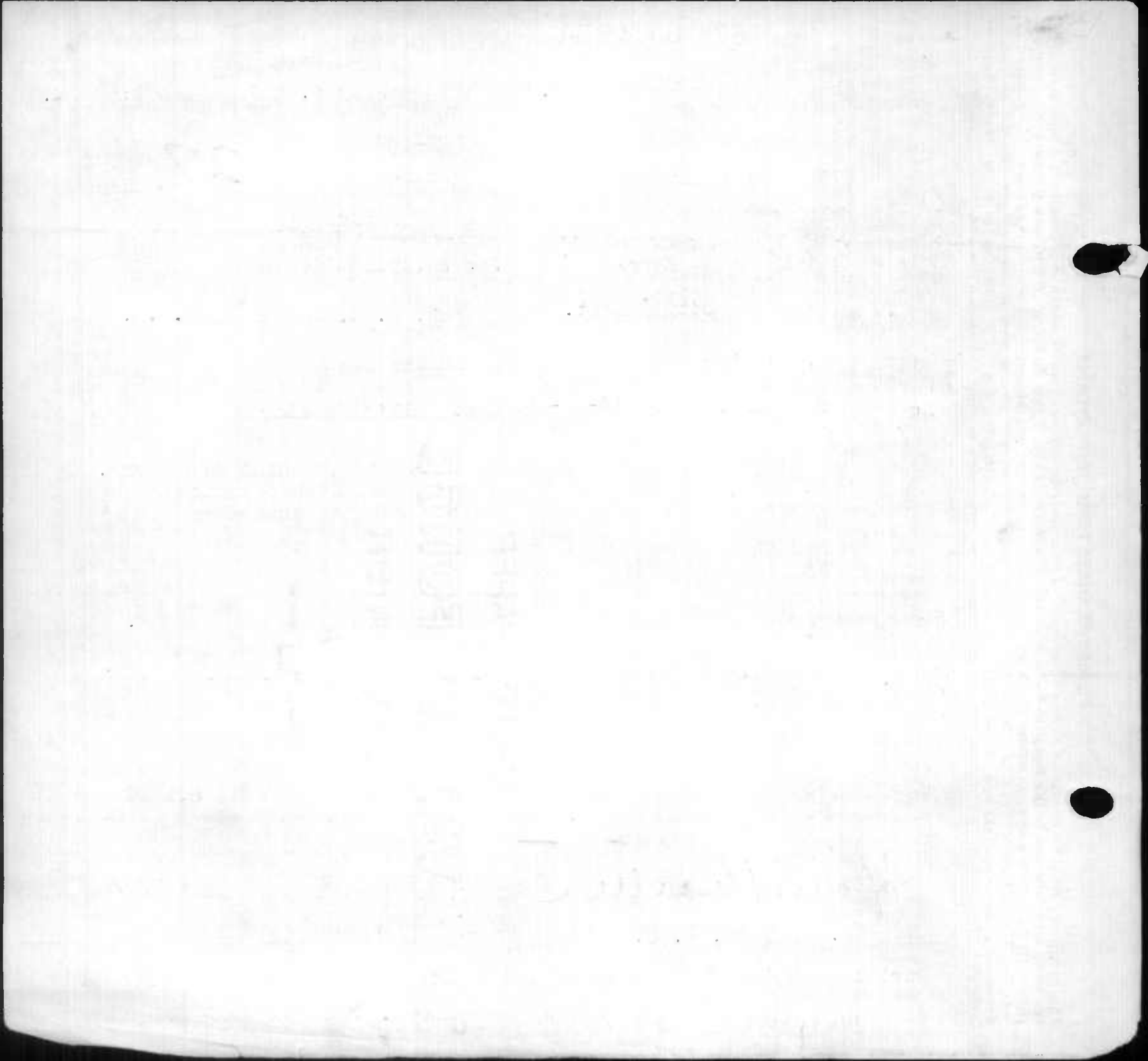
25B. NAME OF REGISTRAR

Robert E. Faldut

25C. FUNERAL DIRECTOR

LEO G. COOK 7200 HARFORD RD

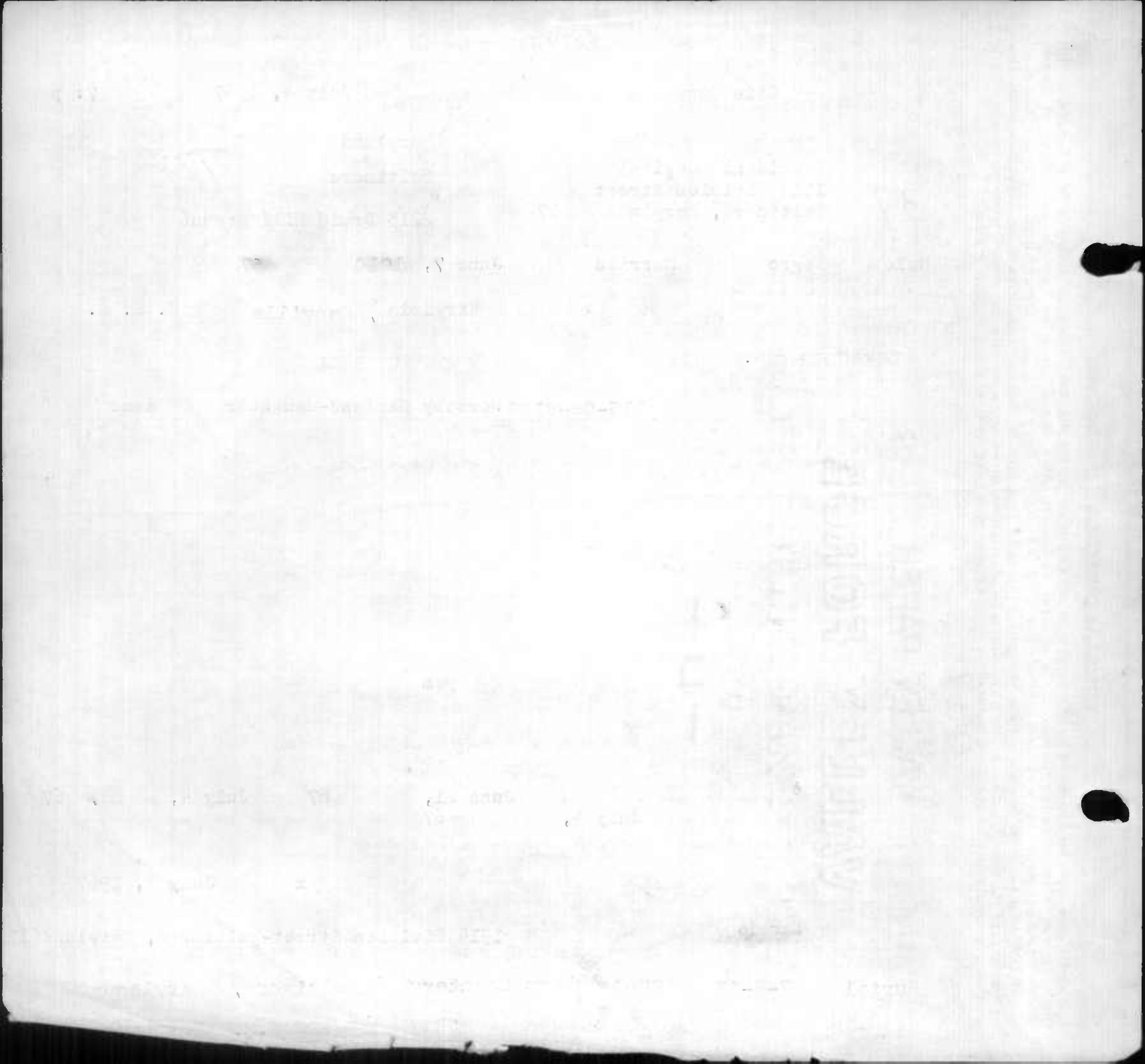
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6503 CERTIFICATE OF DEATH					Registered No. 67 6503				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Otis Gunn					July 4, 1967 7: p M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
Provident Hospital					Maryland				
1514 Division Street					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
Baltimore, Maryland 21217					Baltimore				
D. STREET ADDRESS (If rural, give location)					2213 Druid Hill Avenue				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.		
Male	Negro	Married	June 8, 1910	57					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			
						Virginia, Danville			
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			
U. S. A.			ALEXANDER GUNN			FANNIE BELL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
			215-05-8106			Dorothy Garland-daughter same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO				
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			
2						yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from June 21, 1967 to July 4, 1967, that (I) (we) last saw the deceased alive on July 4, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
<i>[Signature]</i>						July 5, 1967			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
Laredo						1514 Division Street-Baltimore, Maryland (17			
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME OF CEMETERY or CREMATORY			
Burial			7-8-67			Mount Auburn Cemetery			
24D. LOCATION (City, town, or county)			24E. LOCATION (State)						
Baltimore, Maryland									
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
JUL 7 1967			Robert E. [Signature]			MORTON & DYETT F.H. 1701			



67 6504

BALTIMORE CITY HEALTH DEPARTMENT

67 6504

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

STEVEN CLARK

2. DATE AND HOUR PRONOUNCED DEAD

7-6-67

1:50 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

700 Fleet St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

14 S. Freemont Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

8/14/57

9. AGE (In years
last birthday)

9

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

School

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Randolph Clark

14. MOTHER'S MAIDEN NAME

Lamee Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Lamee Clark 14 S. Fremont Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Drowning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Harbor

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

500 S. Calvert Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 6 '67 PM

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell in water while
playing along water edge.

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

CHARLES S. SPRINGATE, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-6-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/10/67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 7 1967

Charles A. Rice 661 W. Barre St.

WALTERS REPORT

REPORT CONTINUED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6505	
BIRTH NO. 67 6505		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH JULY 5, 1967 11:05 P.M.	
1. NAME OF DECEASED (Type or Print) MITCHELL, HARRY L			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21229 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1001 WALNUT AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/01/88
9. AGE (In years last birthday) 79		10. CITIZEN OF WHAT COUNTRY? U S A	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY C & P TELEPHONE CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME MARY E. (MAIDEN NAME UNKNOWN) DEC'D	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO		16. SOCIAL SECURITY NO. 212 10 0866	
17. INFORMANT CATON & WILKENS AVES. HOSPITAL RECORDS-ST. AGNES HOSPITAL			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arterial Thrombosis Left leg ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Septicemia gram neg. Rods. Heart failure Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5-23-67 7-5-67	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 6-1-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene, lower extremity	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 23, 19 67 to JULY 5, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 5, 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.			
23A. SIGNATURE Carl H Matthey		23B. DATE SIGNED 7-6-67	
23C. PHYSICIAN'S NAME (Type) CARL H MATTHEY		23D. ADDRESS CATON & WILKENS AVE. BALTO MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/67	
24C. NAME OF CEMETERY or CREMATORY Lorraine Pk.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1967		25B. NAME OF REGISTRAR Robert E. Fink	
25C. FUNERAL DIRECTOR Witzke F. D.		ADDRESS 4101 Edmondson Av.	

MITCHELL, HARRY J.

JUL 2 1952

MARYLAND DIST.

8 ATTORNEY

1001 WALNUT AVENUE

230100

ST. AGNES HOSPITAL
CATHY AND WILLIAM VEHICLE
8 ATTORNEY, 10. 1952

WHITE HAWK

1001 WALNUT AVENUE, BALTIMORE, MARYLAND

UNKNOWN

MARY E. (MAY 1924 NAME UNKNOWN) DEC 10

UNKNOWN

ST. TO BEAT HOSPITAL DEC 10-11, 1952 HOSPITAL

UNKNOWN

JUL 2 1952

XX

X

C-101 & 111 NAME ARE, 1952

CHIL H MITCHELL

12
R.300

67 6506

BALTIMORE CITY HEALTH DEPARTMENT

67 6506

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELMER REED

2. DATE AND HOUR PRONOUNCED DEAD

July 2, 1967

11:26 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5714 Maggie Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9/23/18

9. AGE (In years last birthday)

48 49

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Attendant

10B. KIND OF BUSINESS OR INDUSTRY

Gasoline Station

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Reed

14. MOTHER'S MAIDEN NAME

Lillian Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service)

16. SOCIAL SECURITY NO.
218-07-0802

17. INFORMANT ADDRESS
Mr. Eugene Cappelli
2716 Pierpont St. - 21230

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis of right coronary artery
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
M.D. ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

7/6/67

23C. NAME OF CEMETERY OR CREMATORY

Glen Haven Cem.

23D. LOCATION

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

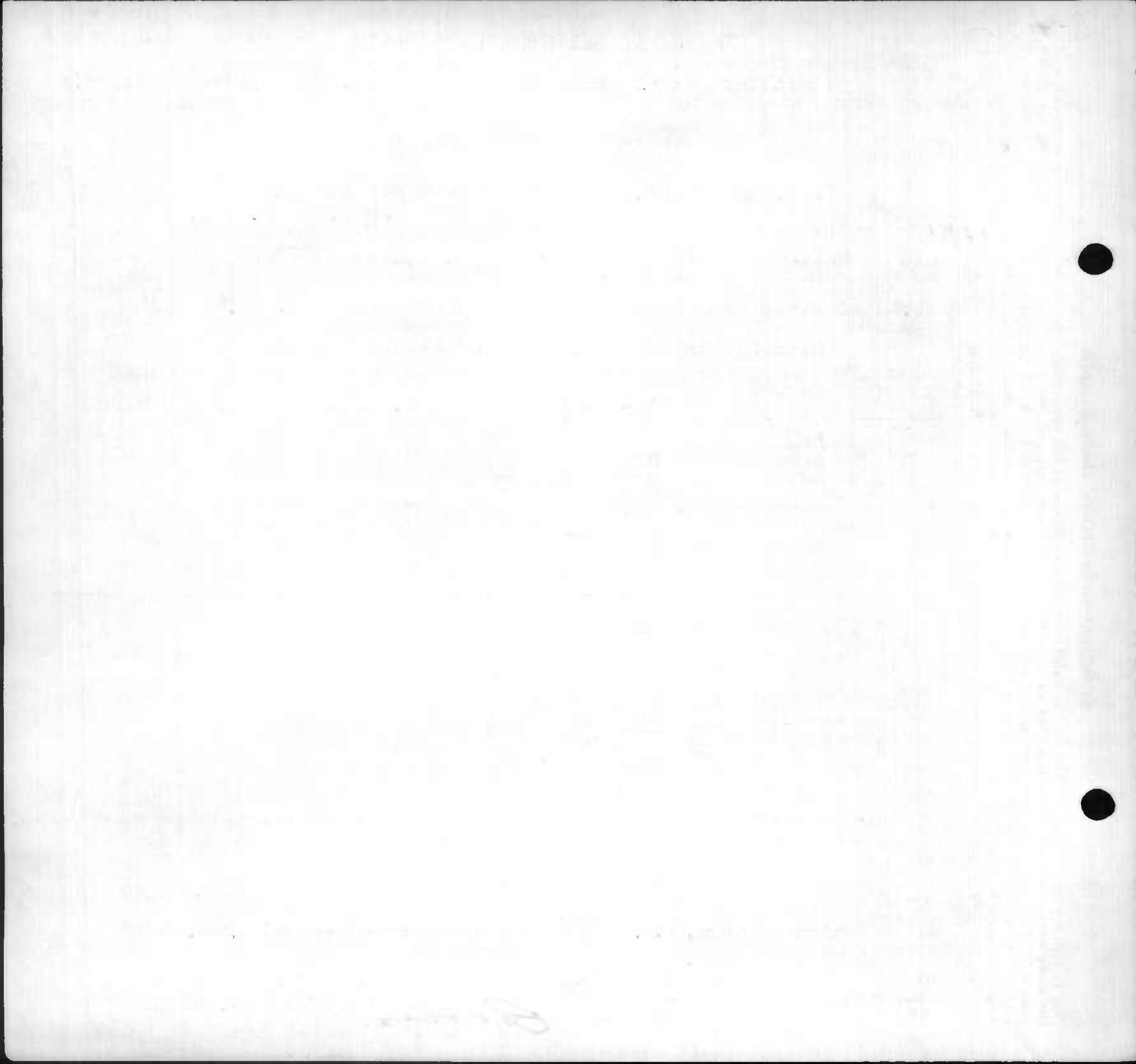
24C. FUNERAL DIRECTOR

Witzke F. D. - 4101 Edmondson Ave.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 6507 CERTIFICATE OF DEATH					Registered No. 67 6507					
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					William Nelson McKINZEY			Thur. July 6, 1967 5:30A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 23 E. Ostend St.					A. STATE Maryland					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21230 23-02					
					D. STREET ADDRESS (If rural, give location) 23 E. Ostend St.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
Male	White	Married		Apr. 17, 1894	73					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Ret. Maintenance Man				Laundry		Prince George Co., Md.		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Wm. Benjamin MckinzeY					Catherine Lowman					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
				217-01-3969		Pearl L. McKinzeY (Wife)		Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Atherosclerosis HD DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 30 minutes 15 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Oct 20 19 50 to 26 July 6 19 67 that (I) (we) last saw the deceased alive on 6 July 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED		
Benjamin Berdamm								July 7 1967		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
Benjamin Berdamm, M.D.					M.D. 615 Hammonds Lane Balto. Md. 21225					
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial			July 10 Mon.		67 Cedar Hill Cem		Brooklyn A A Co Md			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
JUL 7 1967			Robert E. Berdamm		CURTIS E. EVANS 1407 S Charles St 21230					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6508	
BIRTH NO. 67 6508		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SCHULTZ, FRANK			
2. DATE AND HOUR OF DEATH JULY 6, 1967 4:55 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) B CHURCH HOME & HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		8. DATE OF BIRTH 3-N-93 9. AGE (In years last birthday) 74			
D. STREET ADDRESS (If rural, give location) 10 N. CURLEY ST.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAPTAIN - RETIRED - CURTIS BAY		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MIKE SCHULTZ		14. MOTHER'S MAIDEN NAME ANNA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217 14 09558		17. INFORMANT ADDRESS Mrs. Lillian M. Schultz 10 N. Curley St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.01		CAUSE OF DEATH (A) ACUTE PULMONARY EDEMA DUE TO (B) ARTERIOSCLEROTIC HEART DISEASE DUE TO (C) _____			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3 19 67 to July 6 19 67 , that (I) (we) last saw the deceased alive on July 6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Corazon Z. Vergara		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 6, 1967	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA		23D. ADDRESS CHURCH HOME & HOSPITAL 100 N. BROADWAY, BALTIMORE MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/1967		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1967			
25B. NAME OF REGISTRAR John A. Moran Inc.		25C. FUNERAL DIRECTOR ADDRESS 3000 E. Baltimore St.			

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24-1-1942

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 8867 6509
BIRTH NO. 67 6509		CERTIFICATE OF DEATH		
M.E. CASE NO. Mr. John W. Delcher				
1. NAME OF DECEASED (Type or Print) Jenkins Memorial Hospital - Balto., Md.		2. DATE AND HOUR OF DEATH 7-4-67- 7: Pm		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jenkins Memorial Hospital 1000 S. Caton Ave. - Balto., Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore, Maryland B. COUNTY A. A. C. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2202 S. Ritchie Highway		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Wid Married	8. DATE OF BIRTH Oct. 5, 1892- 74	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Renovo, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Delcher		
14. MOTHER'S MAIDEN NAME Emma A. Hayes		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) S.S. 705-07-6479 A-680789 Railroad Retirement		
16. SOCIAL SECURITY NO. Medical Records - M D Kohler		17. ADDRESS Medical Records - M D Kohler		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 17 hrs		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cachexia + weakness		20. DUE TO 2 months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Brain Syndrome		21. DUE TO years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (†) (this hospital) attended the deceased from 7/5 1966 to 7/7 1967 , that (†) (we) last saw the deceased alive on 7/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (†) (We) (did) (did not) view the body after death.				
23A. SIGNATURE J. Raymond Gladue		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/5/67
23C. PHYSICIAN'S NAME (Type) Dr. J. Raymond Gladue		23D. ADDRESS Jenkins Memorial Hosp. 1000 S Caton Ave. (29)		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-1967		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1967		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 29

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. A large 'X' is visible in the top left corner.]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GLENN R. RUNKE

2. DATE AND HOUR PRONOUNCED DEAD

July 4, 1967 7:35 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6317 Lawyers Hill Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11-14-06

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Westinghouse

11. BIRTHPLACE (State or foreign country)

Wisconsin

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard Runke

14. MOTHER'S MAIDEN NAME

Anna Peacock

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Frances W. Runke, 6317 Lawyers Hill Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-8-1967

23C. NAME OF CEMETERY or CREMATORY

Woodlawn Cemetery

23D. LOCATION

Argyle, Wisconsin

July 5, 1967

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1967

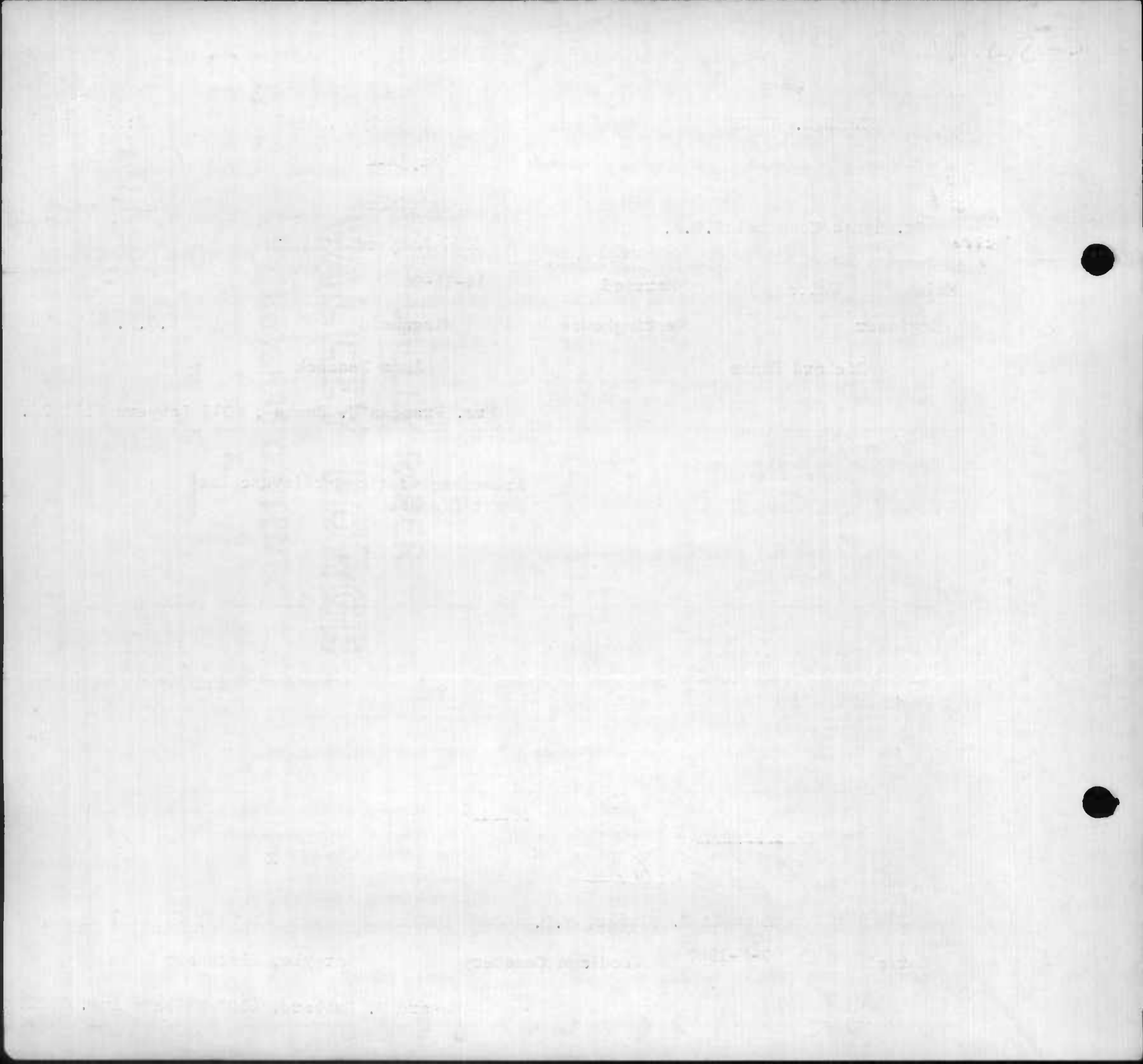
24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 6511	
BIRTH NO. 67 6511		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Irvin W. Schmidt		2. DATE AND HOUR OF DEATH 7-5-67 10⁰⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore ELKRIDGE D. STREET ADDRESS (If rural, give location) 5831 VIRLONA AVE.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED Separated	8. DATE OF BIRTH 6-14-1899	9. AGE (In years last birthday) 68	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S. A.			13. FATHER'S NAME Charles H. Schmidt	
14. MOTHER'S MAIDEN NAME Rose Christopher			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-03-3011		
17. INFORMANT Mrs. Anna E. Heffner, 5831 Viriona Ave. 21227				ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCD OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH Sudden many years			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from September 1965 to July 5 1967 , that (I) (we) last saw the deceased alive on July 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Werner Beck				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-5-67	
23C. PHYSICIAN'S NAME (Type) Werner Beck				23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-67		24C. NAME OF CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1967		25B. NAME OF REGISTRAR Robert E. Faber		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

Handwritten signature

THE UNIVERSITY OF CHICAGO

CHICAGO, ILL. 60637

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6512	
67 6512				67 6512	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) BURKE, RICHARD J.			2. DATE AND HOUR OF DEATH JULY 6, 1967 3:54A.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WILKENS & CATON AVES. BALTIMORE, MD. 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balt. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4416 Alan Drive 1000 CATON AVE. (JENKINS MEMORIAL)		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 07-13-92	9. AGE (In years lost birthday) 74	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES		10B. KIND OF BUSINESS OR INDUSTRY AUTO	11. BIRTHPLACE (State or foreign country) CHICAGO		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Richard Burke			14. MOTHER'S MAIDEN NAME JULIA A. (Guerin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-12-2645	17. INFORMANT WILKENS & CATON AVE ST. AGNES RECORDS - BALTIMORE, MD.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.14-181.0 Acute pulmonary edema Due to Cardiac failure ASCVD. Chronic brain syndrome with the history of 2 CVA's Thyroid lesion history of Ca of bladder Osteoarthritis			INTERVAL BETWEEN ONSET AND DEATH 8 PM to 3:54 AM 8 days 20 yrs		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 6, 1967 to JULY 6, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 6, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (XXX) view the body after death.					
23A. SIGNATURE Carolyn J. Pass M.D.			23B. DATE SIGNED 7-6-67		
23C. PHYSICIAN'S NAME (Type) CAROLYN J. PASS,			23D. ADDRESS M.D. WILKENS & CATON AVES. ST. AGNES HOSPITAL-BALTIMORE, MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-8-1967	24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1967	25B. NAME OF REGISTRAR Robert E. Farley	25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

3:50 PM

JULY 5, 1951

BURNS, ELMOR J.

ST. AGNES HOSPITAL

WATKINS

WILKINS & CATON
BALTIMORE, MD. 21229

0-11-10

FOOD CENTER BAY - (COUNCILING CENTER)

07-11-52

WARRIED

WHITE

USA

CH-10

WED

SALES

JULIA A. []

WILKINS & CATON

ST. AGNES RECORDS - BALTIMORE, MD.

NO

JULY 5, 1951

ST

JULY 5, 1951

JULY 5, 1951

CAROLYN J. PASS

ST. AGNES HOSPITAL - BALTIMORE, MD. 21229

B-525

1. NAME OF DECEASED (Type or Print) MABEL A. BENSON				2. DATE AND HOUR PRONOUNCED DEAD 7-6-67 5:00 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL - DOA				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5111 York Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8/28/1899	9. AGE (In years last birthday) 67	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Hershner				14. MOTHER'S MAIDEN NAME Ina Edith Hershner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-36-4954		17. INFORMANT Dr. Carl F. Benson		ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO (B) DUE TO (C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) CHARLES S. SPRINGATE, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-6-67	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7/8/1967		23C. NAME OF CEMETERY or CREMATORY Druid Ridge		23D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.	
24A. DATE REC'D BY HEALTH DEPT. JUL 7 1967		24B. NAME OF REGISTRAR Robert E. Farber		24C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	

67 6513

WILLIAM HARRIS
A. M. L. E. Y. H. O. R. G. E.
JANUARY 1872

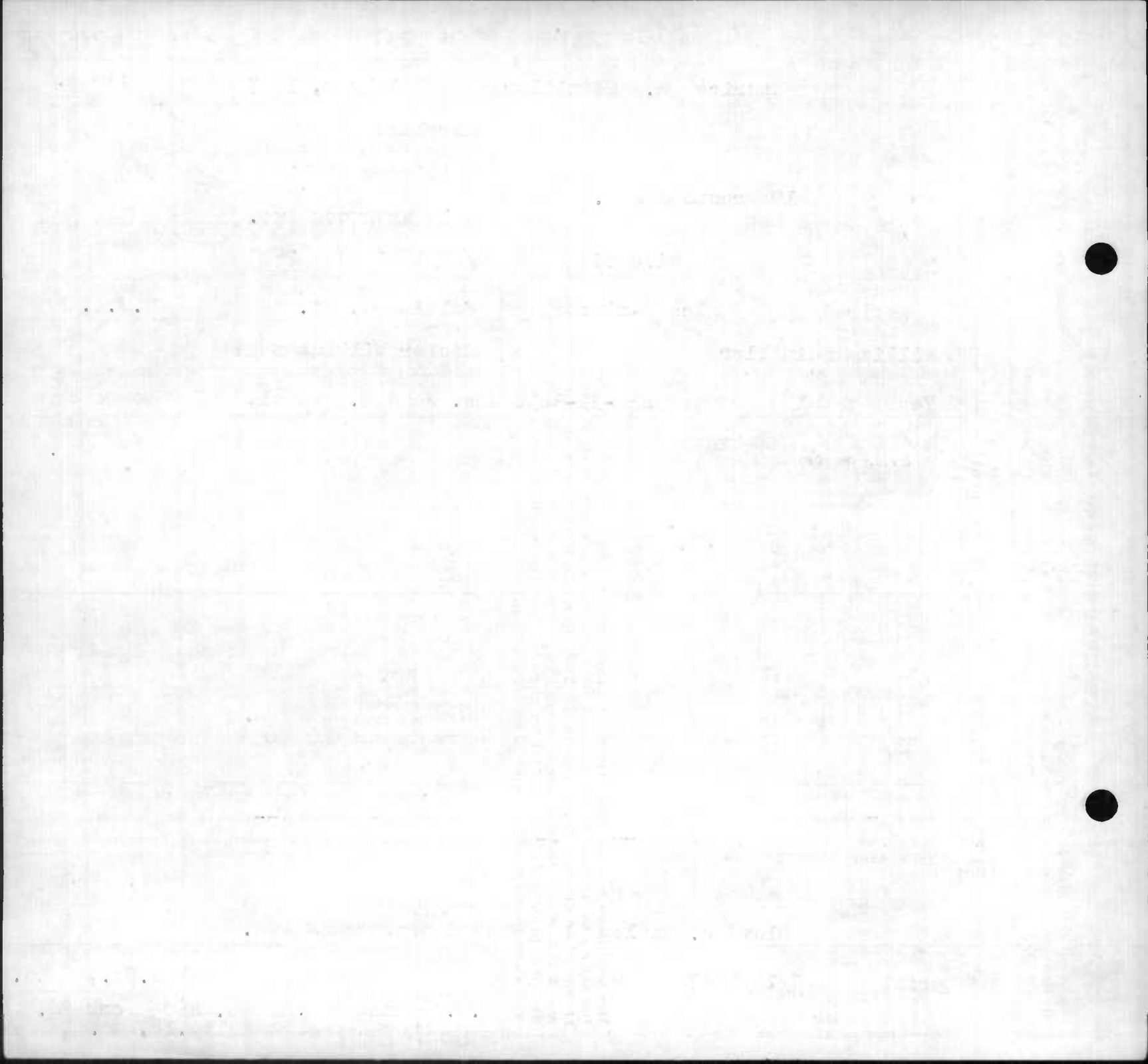
WILLIAM HARRIS

WILLIAM HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.			
67 6514		CERTIFICATE OF DEATH		67 6514			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
Maurice M. Heimiller		July 6, 1967		6:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 4419 Wrenwood Ave.		A. STATE Maryland					
		B. COUNTY					
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
		Baltimore 21212					
		D. STREET ADDRESS (If rural, give location)					
		4419 Wrenwood Ave.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days		
M	W	Widowed	9/25/1892	74			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired		Ice Business	Baltimore, Md.		U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
William Heimiller			Hester Wilkinson				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.				
Yes WWI			220-32-3650				
17. INFORMANT			ADDRESS				
Mrs. John K. Fassel			8507 C Dempster Court				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					2 mo.		
						(A) DUE TO	Hepatoma of liver
						(B) DUE TO	
(C) DUE TO							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)			
D				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 3, 1967 to July 6, 1967, that (I) (we) last saw the deceased alive on July 3, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Lloyd E. Saylor				July 7, 1967			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Lloyd E. Saylor				3902 Greenmount Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY			
Burial		7/10/1967		Lorraine Park			
				24D. LOCATION (City, town, or county) (State)			
				Woodlawn Balto. Co., Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 7 1967		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Matthew

JOSEPH / MASON

2. DATE AND HOUR PRONOUNCED DEAD

July 4, 1967

4:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

708 Homestead Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

708 Homestead Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1/4/1911

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Transportation

11. BIRTHPLACE (State or foreign country)

Boundbrook, N. J.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Mason

14. MOTHER'S MAIDEN NAME

Louise

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-03-9821

17. INFORMANT

Sarah V. Mason

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Extreme Obesity
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 5, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/8/1967

23C. NAME OF CEMETERY or CREMATORY

Presbyterian Church Cem. Pocomake City, Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

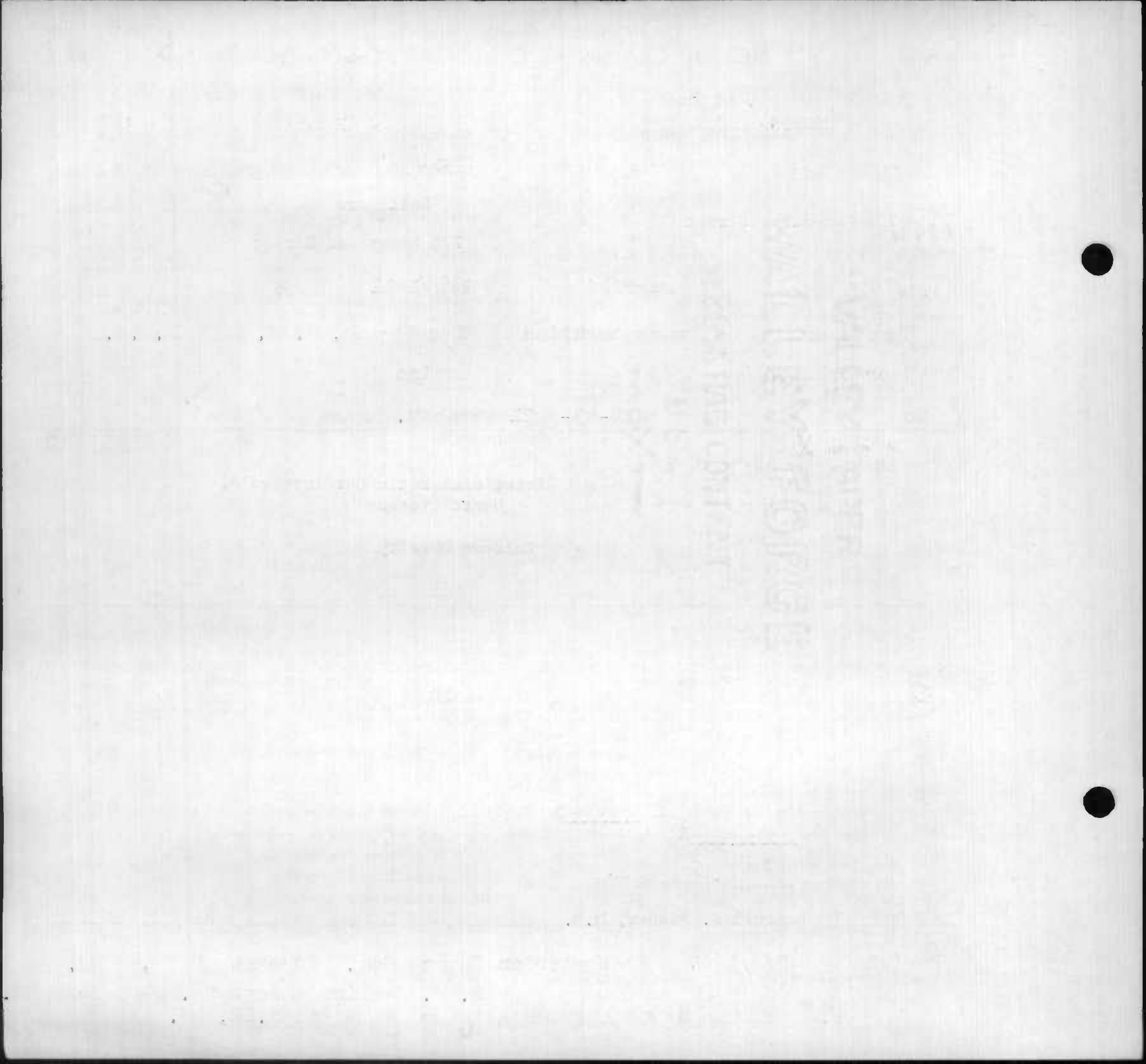
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

H. W. Jenkins & Sons Co. 4905 York Rd.

Balto. 12, Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPT.		Registered No.	
67 6516		67 6516		67 6516	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Leah Wade			2. DATE AND HOUR OF DEATH July 8, 1967 5:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Bolton Hill Nursing Home FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
5. SEX Female			6. RACE Negro		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed			8. DATE OF BIRTH 1-12-97		
9. AGE (In years last birthday) 70			10. If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			11. BIRTHPLACE (State or foreign country) West Virginia		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Cooper			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 218-30-67454		
17. INFORMANT ADDRESS Records: Bolton Hill Nursing Home					
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) congestive heart failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. asthma ventral hernia			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO months years years		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/15 1967 to 7/8 1967 , that (I) (we) last saw the deceased alive on 7/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE al Macht M.D.				23B. DATE SIGNED 7/8/67	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D.				23D. ADDRESS 2 EAST READ ST 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-II-67		24C. NAME OF CEMETERY or CREMATORY Mt Zion Cemetery	
24D. LOCATION (City, town, or county) Baltimore County		24E. STATE (State) Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Talano		25C. FUNERAL DIRECTOR 108 W. ... ADDRESS	

John W. Wada

John W. Wada

John W. Wada

John W. Wada

John W. Wada

John W. Wada

John W. Wada

John W. Wada

1
C-462

67 6517

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6517

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HATTIE CLARK

2. DATE AND HOUR PRONOUNCED DEAD

7-3-67

7:15 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

7-31-67

South Baltimore General Hospital
St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

713 S. Sharp Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3-27-1920

9. AGE (In years
last birthday)

47

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Douth Dakota

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

~~JAMES CLARK~~ ~~XXXXXXXXXX~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

James Clark - 713 Sharp St

18. E 812.41

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Multiple traumatic injuries of

~~XXXXX~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) pelvis and right leg

DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? If in Baltimore City, give exact location)

Hanover Street

122 Ft. North of Hamburg Street 23-01

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
7 1 '67 2:30 PM

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher

M.D. ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

7-3-67

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-7-67

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore-City

(State)

24A. DATE REC'D BY HEALTH DEPT.

BUL 10 1867

24B. NAME OF REGISTRAR

Robert G. Fisher

24C. FUNERAL DIRECTOR

Isaiah L. Brown and Son
108 W. Montgomery Street

ADDRESS

11869.2

67 6518

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6518

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEVI CHASE

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1967

4:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1140 Druid Hill Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

20 South Amity Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Chase

14. MOTHER'S MAIDEN NAME

Bessie Chase

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Bessie Chase 207 N. Amity Street

18. E981X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of chest
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

store

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1140 Druid Hill Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6-30-67 4:40 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☒NOT WHILE
AT WORK ☐21F. HOW DID INJURY OCCUR? Shot while trying
to prevent drugstore hold-up

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-5-67

23C. NAME of CEMETERY or CREMATORY

Mount Auburn

23D. LOCATION

(City, town, or county)

Baltimore City

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 10 1967

Robert E. Johnson

I. L. Brown and Son 108 W. Monte



F-432

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6519

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

TOLBY FIELDS

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1967

3:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Howard

CITY BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Rural - Laurel

63-00

D. STREET ADDRESS (If rural, give location)

Box 98-B Midway Trailer Park

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Mar 18, 1888

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

farmer

10B. KIND OF BUSINESS OR INDUSTRY

farm

11. BIRTHPLACE (State or foreign country)

Pikeville Kentucky

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Fields

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW I

16. SOCIAL
SECURITY NO.

17. INFORMANT

Earl Fields

ADDRESS

Box 98-B Midway
Trailer Park

18. E812.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

highway

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Lower bypass, Route #1,
Howard County, Md.21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6-30-67 2:43 P. M.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by truck

63-00

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

July 1, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

July 5, 1967

23C. NAME of CEMETERY or CREMATORY

Island Creek Family

23D. LOCATION

(City, town, or county)

(State)

Island Creek, Kentucky

24A. DATE REC'D BY HEALTH DEPT.

JUL 10 1967

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

W. H. Donaldson, Laurel, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6520				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6520	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Proctor, Fletcher		7-4-67 6:30P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Provident Hospital, Inc.				Maryland			
39 Baltimore, Maryland 21217				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				1624 McCulloh Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Male	Negro	Married	1-1-11	56			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Unemployed			None		Tennessee		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lester Proctor				Mattie ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes W.W.II				411-03-7458		Mable Proctor (Wife) Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7-4-67 19 to 7-4-67 19, that (I) (we) last saw the deceased alive on 7-4-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Laredo						7-5-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D. 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/11/67		Balto. Nat.		Balto. Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 10 1967		Robert E. Taylor		Wm. B. Chatman		1701 McCulloh, Baltimore.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) SCOTT, Rosie		2. DATE AND HOUR OF DEATH 7-5-67 10:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hosp - BUILDING #21224 4940 Eastern Ave. Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALT. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT. D. STREET ADDRESS (If rural, give location) 4940 Eastern Ave. 21224	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH 11-11-05
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Domestic	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md.		ADDRESS #21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aggravated C.V.A. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe Chronic ASCVD 3+ years II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None KNOWN			INTERVAL BETWEEN ONSET AND DEATH ?
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-2-1965 to 7-5-1967 , that (I) (we) last saw the deceased alive on 7-5-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Patrick Desmond		23B. DATE SIGNED 7-5-67	
23C. PHYSICIAN'S NAME (Type) Patrick Desmond		23D. ADDRESS 4940 Eastern Ave. BALT Baltimore, Maryland # 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-8-67	24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland
25A. DATE RECEIVED DEC 10 1967		25B. NAME of REGISTRAR Marshall W. Jones, Jr.	
25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.		ADDRESS 1735 Harford Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6522 CERTIFICATE OF DEATH					Registered No. 67 6522				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Kincheloe, William Leo</u>					2. DATE AND HOUR OF DEATH <u>7/4/67 7:00 AM</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>U.S. Public Health Service Hospital</u>					A. STATE <u>MD.</u> B. COUNTY <u>Prince Georges</u>				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Capital Heights 66-00</u>					D. STREET ADDRESS (If rural, give location) <u>427 60th Ave</u>				
5. SEX <u>M</u>	6. RACE <u>Cau</u>	7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>2/22/57</u>	9. AGE (In years last birthday) <u>10</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>Leo Kincheloe</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Acres</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>Hosp. Admission Manifest</u>				
18. <u>20431</u> CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Leukemia</u>					(A) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>March 7</u> 19 <u>67</u> to <u>July 4</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 3</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>J. Douglas Morris MD</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>7/4/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. Douglas Morris</u>					23D. ADDRESS M.D. <u>USPHS Hosp. Balto. Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/7/67</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Mary's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>			25C. FUNERAL DIRECTOR ADDRESS <u>G. Wm. Trees Sons Wash. DC.</u>			

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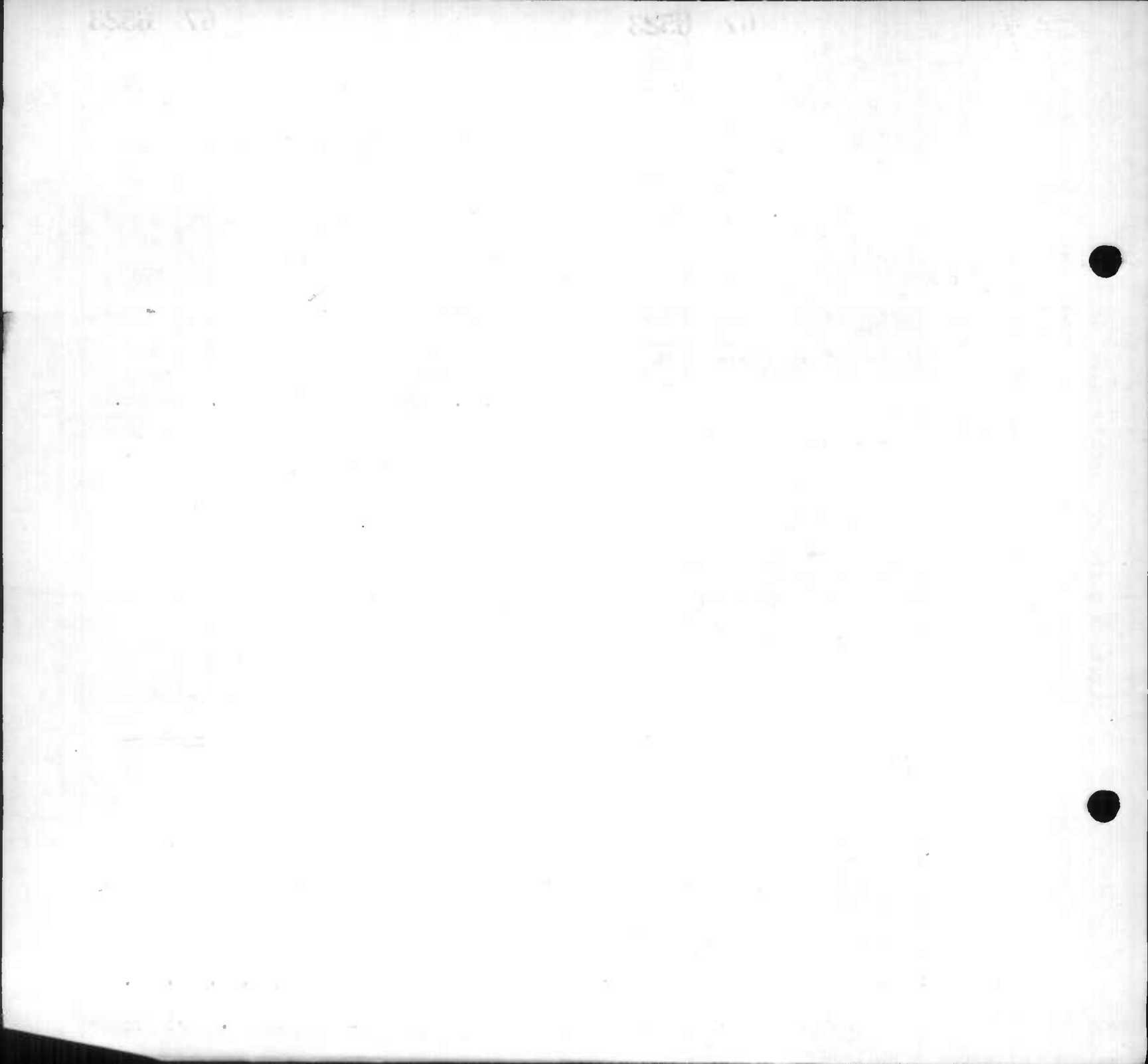
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6523	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 6523 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) FRIEDA E. LINTLINE </div> <div> 2. DATE AND HOUR OF DEATH JULY 6, 1967 1145 P.M. </div> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Balto. General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 24-04 D. STREET ADDRESS (If rural, give location) 1705 BELT ST 21230		
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 11-9-03	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME George Fink			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Norma Muscalli
			ADDRESS 711 N. Rose St.		
18. CAUSE OF DEATH					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 465X I PULMONARY EMBOLIZATION MASSIVE			INTERVAL BETWEEN ONSET AND DEATH		
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-2</u> 19 <u>67</u> to <u>7-6</u> 19 <u>67</u>, that (I) (we) last saw the deceased alive on <u>7-6</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. M. Kaufman				23B. DATE SIGNED 7-7-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 10 67		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
		24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR McGully		25C. FUNERAL DIRECTOR 130 E. Fort Ave	



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

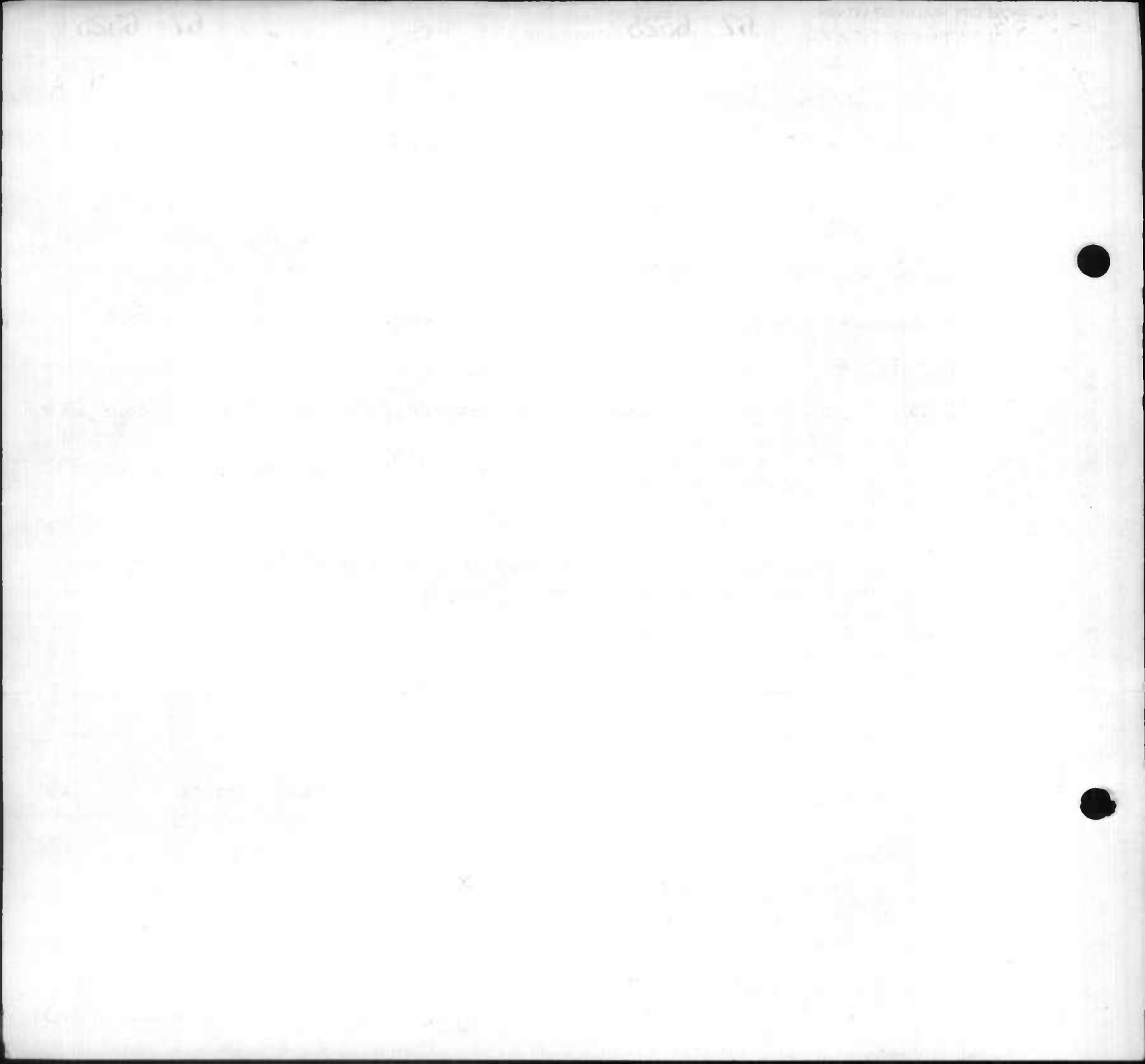
BIRTH NO. 67 6524				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED No. 67 6524	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Simonson, Thomas</i>				2. DATE AND HOUR OF DEATH <i>7/6/67 6:00 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 Johns Hopkins Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Virginia</i> B. COUNTY <i>Farmham</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>V-43</i> D. STREET ADDRESS (If rural, give location) <i>Rt. 1</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (Specify) <i>NEVER MARRIED</i>	8. DATE OF BIRTH <i>8-24-44</i>	9. AGE (In years last birthday) <i>22</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none Self Employed</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>WILLIAM NEWTON SIMONSON</i>				
14. MOTHER'S MAIDEN NAME <i>VIRGINIA LEE PEARSON</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				
16. SOCIAL SECURITY NO. <i>226-64-8185</i>			17. INFORMANT <i>Mrs. Virginia P. Simonson Farmham Vi.</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Pneumothorax</i> <i>Asthma</i>				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>July 1</i> 19 <i>67</i> to <i>July 6</i> 19 <i>67</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>July 6</i> 19 <i>67</i> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE <i>John S. Urbanetti</i> M.D.				23B. DATE SIGNED <i>7/6/67</i>		23C. PHYSICIAN'S NAME (Type) <i>JOHN S. URBANETTI</i>	
23D. ADDRESS M.D. <i>JOHNS HOPKINS HOSPITAL</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/9/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Calvary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Richmond Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>John S. Urbanetti</i>		25C. FUNERAL DIRECTOR <i>John S. Urbanetti</i>		ADDRESS <i>Sons Reisterstown, Md.</i>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6525		CERTIFICATE OF DEATH		67 6525	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HARRY RANDALL (RADETZKY)		JULY 6, 1967 4 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOUSE IN THE PINES-BELVEDERE		A. STATE MARYLAND			
		B. COUNTY BALTIMORE			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				RUSSIA	
13. FATHER'S NAME Louis		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-8882A		17. INFORMANT MRS IDA PERLMAN 8212 MARCIE DRIVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Pneumonia (terminal) (B) DUE TO A SKID (C) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years 5 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/1/1962 to 7/6/1967, that (I) (we) lost saw the deceased alive on 7/5/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/6/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/7/67		24C. NAME of CEMETERY or CREMATORY MOSES MONTIFIORE	
24D. LOCATION (City, town, or county) (State) BACTO MD		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967			
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Sylvan S. [Signature] & Son, Inc. Garrison, Md			



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-00571				67. 6526		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67. 6526	
1. NAME OF DECEASED (Type or Print) STACY LYNN WALKER				2. DATE AND HOUR OF DEATH 7/5/67 14:35 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL BALTIMORE MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE B. COUNTY MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - Dundalk 53-00 D. STREET ADDRESS (If rural, give location) 2002 HOLBORN RD. B1222					
5. SEX FEMALE	6. RACE CAU.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 11/12/67	9. AGE (In years last birthday) 5 MOS.	If Under 1 Yr. Months: Days: Hours: Min. 5 23		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE. WALKER.				14. MOTHER'S MAIDEN NAME JOYCE FEICK.					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS HOSPITAL CHART				
18. 754.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGENITAL HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. TETRALOGY OF FALLOT. CARDIAC ARRHYTHMIA.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II									
19A. DATE OF OPERATION 7/5/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CONGENITAL HEART DIS		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Chris J. Beetel				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7/5/67	
23C. PHYSICIAN'S NAME (Type) CHRIS J. BEETEL				23D. ADDRESS M.D. UNIVERSITY HOSP. BALTI MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.			

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UNIVERSITY HOSP. GALT NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6527		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6527	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) W. EARL TEETS			2. DATE AND HOUR OF DEATH 7-6-67 10:20 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME + HOSP.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk - Dundalk 53-00 D. STREET ADDRESS (If rural, give location) 1911 Sunberry Rd.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-16-07	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Ship Yard		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) West Virginia <i>W. Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? USA.			13. FATHER'S NAME <i>George Teets</i>		
14. MOTHER'S MAIDEN NAME <i>Elba Horner</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-07-2030			17. INFORMANT Mrs. Vena Teets, Dundalk, Md. <i>wife 1911 Sunberry Rd</i>		
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Intracerebral Hemorrhage</i> & days DUE TO (B) <i>Hypertension</i> years DUE TO (C) <i>Atherosclerosis, generalized</i>		
INTERVAL BETWEEN ONSET AND DEATH					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-2 19 67 to 7-6 19 67 , that (I) (we) last saw the deceased alive on 7-6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rodelio M. Lim</i> M.D.				23B. DATE SIGNED 7-6-67	
23C. PHYSICIAN'S NAME (Type) <i>Rodelio M. Lim</i> M.D.				23D. ADDRESS CHA Church Home & Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/67		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT.			
25A. NAME OF REGISTRAR JUL 10 1967		25B. NAME OF REGISTRAR <i>John J. Luda</i>		25C. FUNERAL DIRECTOR Dundalk, Md. 7922 Wise Ave.	

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CHURCH HOME - WASH
1911 Sunday 24

CHURCH HOME - WASH

Roberto M. Jim
Roberto M. Jim

CHURCH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6528	
BIRTH NO. 67 6528		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CARPENTER HOUSTON		2. DATE AND HOUR OF DEATH 7/7/67 10:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital 48		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - Edgemere			
		D. STREET ADDRESS (If rural, give location) 2400 Estelle Ave - #19			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/20/33	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JETERSON CARPENTER		14. MOTHER'S MAIDEN NAME ANNABELLE DAGY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes - WWII		16. SOCIAL SECURITY NO. 234-34-7203		17. INFORMANT (Wife) Edgemere, Md. 21219 Mrs. Clela Carpenter, 2400 Estelle Ave.	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PNEUMONIA		CAUSE OF DEATH (A) ASCVD DUE TO (B) CONGESTIVE FAILURE DUE TO (C) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 20 yrs. 1 week 2 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-6 19 67 to 7-7 19 67 , that (I) was last saw the deceased alive on 7-7 19 67 and that in (my) your opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.					
23A. SIGNATURE Wm K. Wilke				23B. DATE SIGNED 7/7/67	
23C. PHYSICIAN'S NAME (Type) Wm K Wilke				23D. ADDRESS Maryland General Hospital, Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park Cem.	
24D. LOCATION Dorsey, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. R-434
67 6529 CERTIFICATE OF DEATH				67 6529
BIRTH NO.		M.E. CASE NO.		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Mrs. Katie Harman		July 6, 1967		1:50p M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		
Bolton Hall Nursing Home		Maryland		
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
		Baltimore		
		D. STREET ADDRESS (If rural, give location)		
		1520 Gleneagle Rd.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	White	Widowed	July 19, 1880	86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife		At Home		Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
George Pickering		Drucillia Pickering		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No				Mr. Emmanuel G. Harman 106 S. Broadview Blvd
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
420.0 I		arteriosclerotic heart disease		
ANTECEDENT CAUSES		(A) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		
		(C) DUE TO		
II		INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE E. Ellsworth Cook M.D.				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook M.D.				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		7 10 67		Mt. Olivet
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
JUL 10 1967		Robert E. Taylor		130 E. Fort Ave

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6530	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 6530 CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Mary T. Kelly			2. DATE AND HOUR OF DEATH July 6, 1967. 3:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Harford Gardens Nursing Home			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 4618 Elsdor Ave.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/18/1878	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Costume Maker		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Sauerwald			14. MOTHER'S MAIDEN NAME Rosa R. Wolf		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-01-9124	17. INFORMANT ADDRESS Mrs. Agnes B. Seipp 1601 Abbottston St.		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion Coronary Sclerosis arterio Sclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility - Secondary Arteriosclerosis malnutrition					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 3, 1967 to July 6, 1967 , that (I) (we) last saw the deceased alive on July 6, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter A. Anderson			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 6 67
23C. PHYSICIAN'S NAME (Type) Walter A. Anderson			23D. ADDRESS M.D. 3001 Shannen Drive Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/10/67	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967	25B. NAME OF REGISTRAR Robert E. [Signature]	25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214			

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Patient's Name: *Robert E. Sabogal*
 Address: *601 N. V.M.H.*
 Funeral Director: *Leonard J. Buck Inc.*
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 530				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6531			
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
				FORTE, JOSEPH SAMUEL				7-6-67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				5. AGE (In years)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL				A. STATE Md.				B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				D. STREET ADDRESS (If rural, give location) 1120 East 36th. Street			
5. SEX Male				6. RACE White				7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			
8. DATE OF BIRTH 02-02-02				9. AGE (In years last birthday) 65				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? AMERICAN				13. FATHER'S NAME Vincent Forte			
14. MOTHER'S MAIDEN NAME SARAH MACRONI				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.1				16. SOCIAL SECURITY NO. 218-36-5159			
17. INFORMANT CHART				ADDRESS UNION MEMORIAL HOSP.				18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH SEVERE HEMORRAGE				INTERVAL BETWEEN ONSET AND DEATH 7-5-67				(A) DUE TO			
ANTECEDENT CAUSES ABDOMINAL ANEURYSM				(B) DUE TO				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				19A. DATE OF OPERATION 7-6-67				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ANEURYSM			
20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from 7-5-67 to July 6 1967 , that (I) (we) last saw the deceased alive on July 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>[Signature]</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7-6-67			
23C. PHYSICIAN'S NAME (Type) JORGE SABOGAL				23D. ADDRESS THE UNION MEMORIAL HOSPITAL				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/10/67				24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.				24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967				25B. NAME OF REGISTRAR Robert E. Sabogal				25C. FUNERAL DIRECTOR Leonard J. Buck Inc. Balto. Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6532	
BIRTH NO. 67 6532					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Fink, Millard, J.			2. DATE AND HOUR OF DEATH 7-7-67 2³⁵ A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21224		
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES Hospital 49			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21224 26-11		
			D. STREET ADDRESS (If rural, give location) 3207 Elliott Street		
5. SEX Male	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 4-29-1905	9. AGE (In years last birthday) 62 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Die setter		10B. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal	11. BIRTHPLACE (State or foreign country) BALTIMORE, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Fink, Andrew F.			14. MOTHER'S MAIDEN NAME Heindley Elizabeth, E.		
15. Was Deceased ever in U. S. Armed Forces? (Yes, no (unknown)) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-10-8554A	17. INFORMANT chart: JOHN C. FINK 1010 S. BOULDIN ST. BALTO., 24, MD.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 157X I			CAUSE OF DEATH (A) Hepatic coma (B) CA of the pancreas (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 6-10-67		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-10-1967 to 7-7-1967 , that (I) (we) last saw the deceased alive on 7-7-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. Ruyel				23B. DATE SIGNED 7-7-67	
23C. PHYSICIAN'S NAME (Type) Melito Torres				23D. ADDRESS 441 S. Ellwood Ave. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-11-67		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEM.	
		24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD. BA.CO., MD.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR JUL 10 1967		25C. FUNERAL DIRECTOR 901 S. CONKLING ST. BALTIMORE, 24, MD.	

State of New York

County of Albany

In SENATE,

January 2, 1977

REPORT

OF THE

COMMISSIONER OF

THE STATE OF NEW YORK

TO THE SENATE

AND ASSEMBLY

FOR THE YEAR 1976

AND FOR THE YEAR 1977

TO THE SENATE

AND ASSEMBLY

FOR THE YEAR 1976

AND FOR THE YEAR 1977

TO THE SENATE

AND ASSEMBLY

FOR THE YEAR 1976

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TO THE SENATE

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FOR THE YEAR 1976

AND FOR THE YEAR 1977

TO THE SENATE

AND ASSEMBLY

FOR THE YEAR 1976

AND FOR THE YEAR 1977

TO THE SENATE

AND ASSEMBLY

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State of New York

County of Albany

In SENATE,

January 2, 1977

REPORT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6533		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6533	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) PUKK MICHAEL			7-8-67 12:45AM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto. Co.		
40 ST. AGNES HOSPITAL			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21207 53-00		
D. STREET ADDRESS (If rural, give location) 1543 LANGFORD RD					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10-28-01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED (Welder)		10B. KIND OF BUSINESS OR INDUSTRY Orn. Iron Eks.	11. BIRTHPLACE (State or foreign country) EUROPE (Estonia)		12. CITIZEN OF WHAT COUNTRY? ESTONIA
13. FATHER'S NAME Alexander Pukk			14. MOTHER'S MAIDEN NAME Elizabeth Koppli		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 216-36-6851	17. INFORMANT ADDRESS OLD ADMISSION SLIP 5-23-67		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Metastatic prostate carcinoma			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 7-7-67 1967 to 7-8 1967 , that (X) (we) last saw the deceased alive on 7-8 1967 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Korbuly			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-8-67
23C. PHYSICIAN'S NAME (Type) S. KORBULY			23D. ADDRESS ST AGNES HOSPITAL-CATON & WILKENS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/1967		24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR R. B. E. Jackson		25C. FUNERAL DIRECTOR ADDRESS St. Ann's Funeral Home, Woodlawn, Md.	

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12: 5PM

7-9-67

BUCK MICHAEL

MARYLAND

ST AGNES HOSPITAL

BALTIMORE 21207

ST. AGNES HOSPITAL

1545 LANSFORD RD

67

10-26-67

MALE WHITE

67

RETIRED

OLD ADMISSION SLIP 5-23-67

7-9-67

X

67

7-9-67

7-9

X

X

X

7-9-67

ST AGNES HOSPITAL-CATONSVILLE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67. 6534		67. 6534		67. 6534	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ZEPP, JOSEPH G.		JULY 6, 1967		11:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
FRANKLIN SQUARE HOSP.		Maryland Anne Arundel Co			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Glen Burnie Road 52-00			
		D. STREET ADDRESS (If rural, give location)			
		#141 Seagrave			
5. SEX	6. RACE	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: Hours: Min.
EM	W		12/8/10	56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
STEAM FITTER		Construction		W. VA.	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
GEORGE ZEPP		IDA TRAYERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NOT KNOWN No		236-14-9424		Mrs. Glenna M. Zepp (Wife) HOSP. CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
163X1		CARCINOMA of the LUNG		± 12 Mos	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/5/1967 to 7/6/1967, that (I) (we) last saw the deceased alive on 7/6/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Rene C. Meneer				7/6/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D. Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		July 10, 1967		Glen Haven Mem. Park	
				Glen Burnie, Maryland	
25A. DATE RECEIVED		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 10 1967		Robert E. Tarkenton		R.V. Singleton	
				Address: Singleton Funeral Home, Glen Burnie, Md.	

Highland Avenue Road
Glen Burnie Road
1741 2nd Avenue

Construction

Mr. Glenn M. Zapp (W.R.)
2nd Ave. 4

No

General July 10, 1961 Glen Burnie Mtn. Park Glen Burnie
R.V. Zapp
2nd Avenue 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6535	
BIRTH NO. 67 6535		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) IDA BERNGARTT		2. DATE AND HOUR OF DEATH JULY 4, 1967 13:30 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BELVEDERE NURSING HOME 2525 W. BELVEDERE AVENUE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) ESPLANADE APARTMENTS, 2525 ELITAW PLACE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH MAY 8, 1894	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTH PLACE (State or foreign country) NEW YORK CITY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME NATHAN BURTNICK			14. MOTHER'S MAIDEN NAME BERTHA TEPSE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-48-1883	17. INFORMANT ADDRESS MRS. HARRY PHILLIPS, 407 TEMPLE GARDEN APTS.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 170X I		CAUSE OF DEATH (A) DUE TO C of Breast (B) DUE TO (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-4-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-4-67 to 7-4-67 , that (I) (we) last saw the deceased alive on 7-4-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DR. JEROME COLLIER M.D.				23B. DATE SIGNED 7-5-67	
23C. PHYSICIAN'S NAME (Type) DR. JEROME COLLIER M.D.				23D. ADDRESS 2217 SOUTH AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/6/67		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REIST., RD.	

Co. of 100

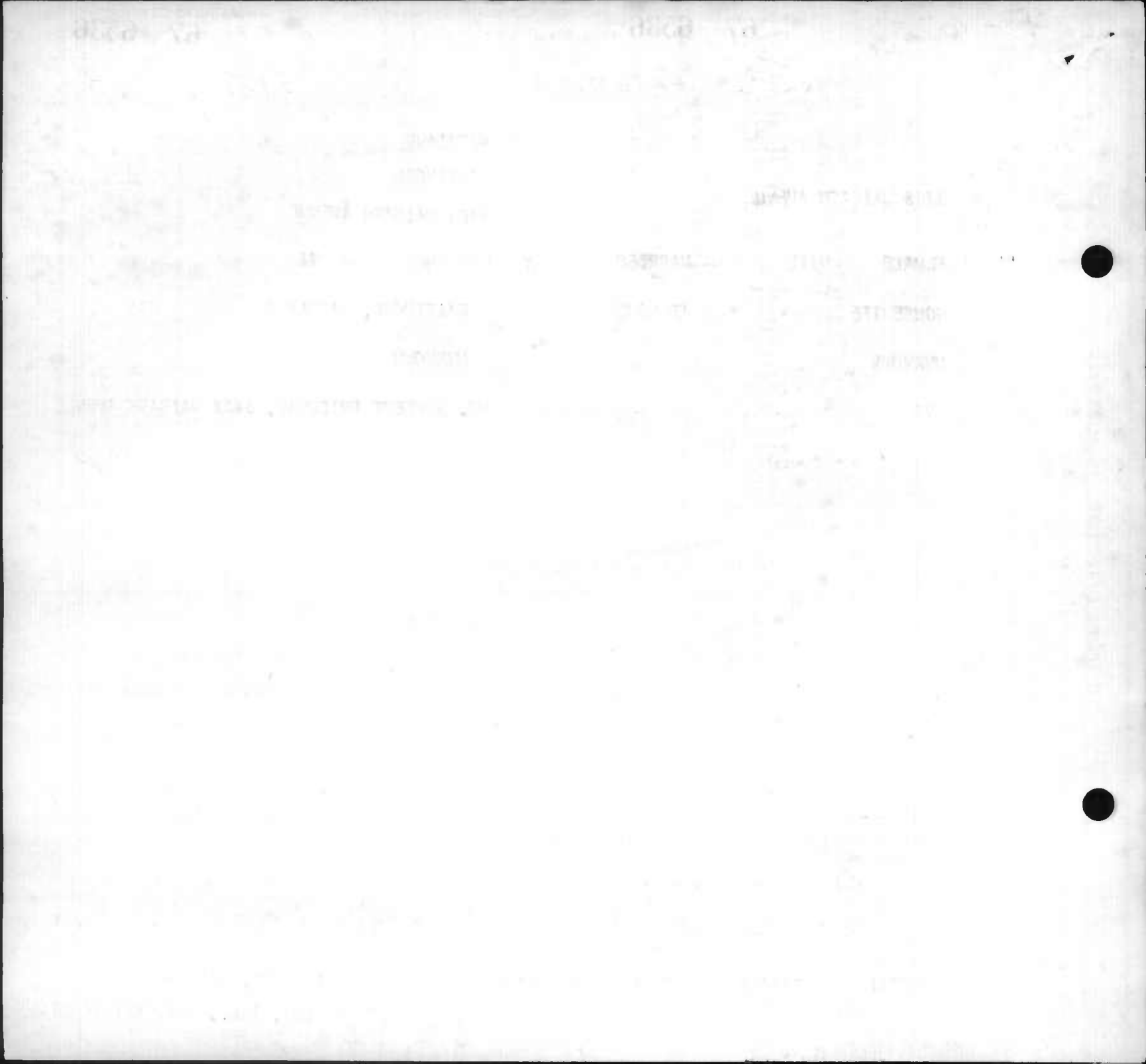
James H. H. H.

200 05

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6536	
67 6536				CERTIFICATE OF DEATH	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 635</p> <p>M.E. CASE NO.</p> </div> <div> <p>1. NAME OF DECEASED (Type or Print) MOLLIE FRIEDMAN</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 7/5/67 3 A M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>3408 WALBASH AVENUE</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p> <p>A. STATE MARYLAND</p> <p>B. COUNTY</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</p> <p>BALTIMORE</p> <p>D. STREET ADDRESS (If rural, give location)</p> <p>3408 WALBASH AVENUE</p>		
<p>5. SEX</p> <p>FEMALE</p>	<p>6. RACE</p> <p>WHITE</p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</p> <p>MARRIED</p>	<p>8. DATE OF BIRTH</p> <p>71</p>	<p>9. AGE (In years last birthday)</p> <p>71</p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>HOUSEWIFE</p>
<p>11. BIRTHPLACE (State or foreign country)</p> <p>BALTIMORE, MARYLAND</p>			<p>12. CITIZEN OF WHAT COUNTRY?</p> <p>USA</p>		
<p>13. FATHER'S NAME</p> <p>UNKNOWN</p>			<p>14. MOTHER'S MAIDEN NAME</p> <p>UNKNOWN</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>NO</p>			<p>16. SOCIAL SECURITY NO.</p> <p>UNKNOWN</p>		
<p>17. INFORMANT</p> <p>MR. NORBERT FRIEDMAN, 3408 WALBASH AVENUE</p>			<p>ADDRESS</p>		
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>Cerebral Thrombosis</p> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>5 days</p>					
<p>19. ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>Arteriosclerotic Heart Disease</p> <p>5 years</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p>none</p>					
<p>19A. DATE OF OPERATION</p> <p>D</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p> <p>No</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p> <p><input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from July 8 19 62 to July 5 19 67.</p> <p>that (I) (we) last saw the deceased alive on July 5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE</p> <p>Manuel Levin</p> <p>M.D. <input type="checkbox"/> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>				<p>23B. DATE SIGNED</p> <p>7/5/67</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p>MANUEL LEVIN</p> <p>M.D.</p>				<p>23D. ADDRESS</p> <p>4818 REISTERSTOWN RD, BALTO MD.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p>BURIAL</p>		<p>24B. DATE</p> <p>7/6/67</p>		<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p>CHIZUK AMINO (ARLINGTON)</p>	
<p>24D. LOCATION (City, town, or county) (State)</p> <p>BALTIMORE, MARYLAND</p>		<p>25A. DATE RECEIVED BY HEALTH DEPT.</p> <p>JUL 10 1967</p>			
<p>25B. NAME OF REGISTRAR</p> <p>Robert E. J. J.</p>		<p>25C. FUNERAL DIRECTOR</p> <p>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				Registered No. 67 6537	
BIRTH NO. 67 6537		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Francis (Frank) X. Ely			
2. DATE AND HOUR OF DEATH July 4. 1967 2.30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Middler River D. STREET ADDRESS (If rural, give location) 1705 Wilson Point Rd.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 5/5/1897	9. AGE (In years last birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Egg Merchant
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Self Emp.	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME George Ely			14. MOTHER'S MAIDEN NAME Emily Alexander		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.1		16. SOCIAL SECURITY NO. 216-32-8913	17. INFORMANT ADDRESS Mrs E. Scott Moore Joppa Rd. Perry Hall		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis		CAUSE OF DEATH (A) DUE TO ASCVD		INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		10 yrs.	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emphysema					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 54 to July 19 67 , that (I) was last saw the deceased alive on July 3 19 67 and that in my our opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death.					
23A. SIGNATURE Charles M. Kerr M.D.				23B. DATE SIGNED July 5, 67	
23C. PHYSICIAN'S NAME (Type) Charles M. Kerr M.D.				23D. ADDRESS 6801 Belair Rd Baltimore 6	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/67		24C. NAME OF CEMETERY or CREMATORY Gardens Of Faith Cem.	
24D. LOCATION (City, town, or county) Baltimore Md		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6538		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6538	
M.E. CASE NO. SHAW (Shawe)		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SHAW, NORMAN M.		2. DATE AND HOUR OF DEATH 6/28/67 10.10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY USA C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3633 W. BELVEDERE			
5. SEX WM	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3/14/97	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME XXXXXXXX Frisby T. SHOW			
14. MOTHER'S MAIDEN NAME XXXXXXXX Annie M. Jacobs		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NW I			
16. SOCIAL SECURITY NO. 214 01 9922		17. INFORMANT ADDRESS Md. Norman L. Shaw 3633 W. Belvedere Ave. Balto.			
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Carcinoma of esophagus & obstruction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3 6/26/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GASTROSTOMY		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 6/17 1967 to 6/28 1967 , that (B) (we) last saw the deceased alive on 6/28 1967 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. Pachan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/28/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Sinai Hospital, Baltimore, Maryland.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-67		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Gardens	
24D. LOCATION (City, town, or county) (State) Balto. Co. Maryland.		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967			
25B. NAME OF REGISTRAR Robert E. Frisby		25C. FUNERAL DIRECTOR William E. Johnson		ADDRESS 8521 Loch Raven Bl. Balto. Md.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6539				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6539	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>George Henry Klinckfelter</i>				2. DATE AND HOUR OF DEATH <i>July 5 1967</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00 5526 Mattfeldt Ave</i>				A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-15</i>			
				D. STREET ADDRESS (If not, give location) <i>5526 Mattfeldt Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>July 21 1875</i>	9. AGE (In years last birthday) <i>91</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Gas & Elect Co</i>		11. BIRTH PLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Calvin Klinckfelter</i>				14. MOTHER'S/MAIDEN NAME <i>Eleanor Luckabaugh</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>21205 5864</i>		17. INFORMANT <i>Lele M Klinckfelter</i>			
				ADDRESS <i>5526 Mattfeldt Ave</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.1 I</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO <i>Coronary Occlusion Sudden</i> (B) DUE TO <i>Generalized Arteriosclerosis 10 yrs</i> (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>0077</i> 19 <i>58</i> to <i>July 5</i> 19 <i>67</i> . that (I) <i>(x)</i> last saw the deceased alive on <i>June 19 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Charles F O'Donnell</i>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>Charles F O'Donnell</i>				23D. ADDRESS M.D. <i>7501 York Rd</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-7-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Mary's</i>		24D. LOCATION (City, town, or county) (State) <i>Roland Ave, Balto Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 10 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR <i>Burgess Funeral Home</i>			
				ADDRESS <i>3631 Falls Rd</i>			

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

1
F-620 67. 6540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6540

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JOHN O FRAZIER				2. DATE AND HOUR PRONOUNCED DEAD 7-6-67 10:50 AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITAL - DOA				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto. Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1628 Dartford Road 21221			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) NEVER	8. DATE OF BIRTH JAN 5, 1966	9. AGE (In years last birthday) 1 yr. 4 mos.	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRAZIER				14. MOTHER'S MAIDEN NAME REBECCA PARRISH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT REBECCA WISE		ADDRESS ABOVE	
18. E 916.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Asphyxia (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Carbon monoxide (B) DUE TO Conflagration (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1628 Dartford Road 53-00			
21D. TIME OF INJURY (APPROX.) 7 6 '67 10:09 AM		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Kitchen stove caught fire			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) CHARLES S. SPRINGATE, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-6-67	
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 7/8/67		23C. NAME OF CEMETERY or CREMATORY OAK LAWN		23D. LOCATION (City, town, or county) (State) BALTO. MD.	
24A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		24B. NAME OF REGISTRAR Robert E. Farber		24C. FUNERAL DIRECTOR J.G. CONNELLY		ADDRESS 300 MACE	

NALLIEN TUBS

NALLIEN TUBS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6541		CERTIFICATE OF DEATH		67 6541	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SHOEMAKE JOHN LEONARD		JULY 6, 1967 6.30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
UNION MEMORIAL HOSPITAL		MD BALTIMORE Co.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		53.00			
		D. STREET ADDRESS (If rural, give location)			
		RT. # 14, BOX 192			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	MARRIED	06-23-18	49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
FLEET DRIVE				PENNSYLVANIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
GEORGE SHOEMAKE		BERTHA SHORT		AMERICAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNK		212-10-6313		MRS. VIRGINIA SHOEMAKE RT#14 BOX 92	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6-30-67				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 06-07-1967 to 7-6-1967, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Saravut SriFuengfong M.D.				7-6-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
SARAVUT SRIFUENG FONG M.D.				THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
REMOVAL		7/8/67		FROSTBURG MEM. PARK	
				FROSTBURG MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 10 1967		R. C. G. Foster		J. G. CONNELLY SONS 300 MACE	
				FROSTBURG MD	

1120 Va

1120 Va

1120 Va

1120 Va

+

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY DEPARTMENT				Registered No. 67 6542	
BIRTH NO. 67 6542		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FLORENCE JAY			
2. DATE AND HOUR OF DEATH 7/4/67 5:30 AM		3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND GEN'L HOSP. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE, MARYLAND 48			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VIRGINIA B. COUNTY RICHMOND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-43			
D. STREET ADDRESS (If rural, give location) 7741 ROCKFALL DR.		5. SEX F 6. RACE Can 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			
8. DATE OF BIRTH 1907 APRIL 11		9. AGE (In years lost birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? USA		10B. KIND OF BUSINESS OR INDUSTRY At Home	
13. FATHER'S NAME DAVID TORRENCE		14. MOTHER'S MAIDEN NAME ELWINA SIMPSON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. —		17. INFORMANT SDA Frederick Jay - Same		ADDRESS	
18. 452 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pneumonia - DUE TO (B) ASPIRATION - DUE TO (C) BERRY ANEURYSM.		INTERVAL BETWEEN ONSET AND DEATH 1 day - 1 day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/29/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BERRY ANEURYSM		20A. AUTOPSY? (Yes or No) —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (1) (this hospital) attended the deceased from 6-14-67 19 to 7-4-67 19 that (1) (we) last saw the deceased alive on 7-4-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert M. Barranco		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/4/67	
23C. PHYSICIAN'S NAME (Type) ROBERT M. BARRANCO		23D. ADDRESS MARYLAND GEN'L HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/67		24C. NAME OF CEMETERY OR CREMATORY St. Margaret's Church	
24D. LOCATION (City, town, or county) Annapolis		(State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Barranco		25C. FUNERAL DIRECTOR Robert E. Barranco	
ADDRESS		ADDRESS			

Shed to

Shed to

1911
10

1911

67 6543

BALTIMORE CITY HEALTH DEPARTMENT

67 6543

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DOROTHY HUSKETH

2. DATE AND HOUR PRONOUNCED DEAD

July 6, 1967 5:28 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 4726 Wakefield Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4726 Wakefield Road

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

6-15-1912

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Teacher

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Longbranch N.J.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

R. v. J. Ward

14. MOTHER'S MAIDEN NAME

Ann Welsh

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; if yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Carolyn Thomas, 343 Robert St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Dissecting aneurysm of aorta

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

July 7, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-10-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 10 1967

Robert E. Taylor, M.D.

Charles R. Law, 802 Madison Ave.

THE UNIVERSITY OF CHICAGO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 6544

BIRTH NO.

67 6544

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

OTIS
WILLIAMS, PRESTON, WILLIAMS

2. DATE AND HOUR OF DEATH

7-7-67

11:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

UNION MEMORIAL HOSP.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

44

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give location)

BALTIMORE

13-03

D. STREET ADDRESS (If rural, give location)

2544 MADISON AVENUE

5. SEX

M

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

5/26/1905

9. AGE (In years
last birthday)

62

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED COOK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

WILLIAMS ARNSTEAD

14. MOTHER'S MAIDEN NAME

LUCY GRIFFIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes II

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Gladys Williams, 2544 Madison Ave.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Bronchopneumonia

(B) DUE TO

(C)

W. K. Wu

INTERVAL BETWEEN ONSET AND DEATH

6 HOURS

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 7, 1967 to July 7, 1967, that (I) (we) last saw the deceased alive on July 7, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Raul V. Disquitado

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

7-7-67

23C. PHYSICIAN'S NAME (Type)

DR. RAUL V. DISQUITADO

23D. ADDRESS

M.D. THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-7-67

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 10 1967

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Charles R. Law, 802 Madison Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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George William, 221, 1st St.,

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 326		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6545	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BOUTCHYARD, JUDITH F.		2. DATE AND HOUR OF DEATH 7-4-67 5:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND, CECIL C. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) PERRYVILLE 57-00 D. STREET ADDRESS (If rural, give location) RICHMOND ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-23-44	9. AGE (In years last birthday) 23	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Bolton, England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CLIFFORD FALLOWS		14. MOTHER'S MAIDEN NAME DOROTHY BYRD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 420-58-3764		17. INFORMANT Gary C. Boutchyard, Perryville, Maryland.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) UREMIC COMA		CAUSE OF DEATH (A) DUE TO RENAL FAILURE (B) DUE TO SUBACUTE GLOMERULOPHAPRITIS		INTERVAL BETWEEN ONSET AND DEATH 15 MONTHS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (h) (this hospital) attended the deceased from 3-7 19 67 to 7-4 19 67 , that (h) (we) last saw the deceased alive on 7-4 19 67 and that in (h) (our) opinion death occurred on the date and hour and from the causes stated above. (h) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Major W. Bradshaw		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-4-67	
23C. PHYSICIAN'S NAME (Type) MAJOR W. BRADSHAW		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-67		24C. NAME OF CEMETERY or CREMATORY Hopewell Cemetery	
24D. LOCATION (City, town, or county) (State) Pont Deposit, Maryland.		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland.			

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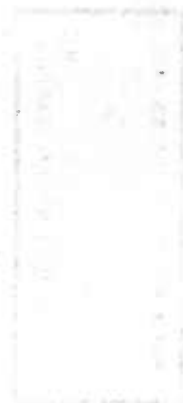
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6546		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6546	
M.E. CASE NO. Mrs MARGARET STRAYER		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH July 7 1967 1 30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
HOUSE IN PINGS BELVEDERE		HOUSE IN PING BELVEDERE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		2525 WEST BELVEDERE AVE			
		D. STREET ADDRESS (If rural, give location)			
		BALTIMORE MARYLAND 27-17			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	WIDOW	11-22-1870	96	U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		—		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
ANDREW HAINES			KATHERINE TRIMMER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO NO		217-48-2276		FLORENCE SAVILLE-1310 W. COLD SPRING LANE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTecedent CAUSE		Acute Myocardial Infarction		Seven Hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (e.g., atherosclerosis, etc.)		(A) DUE TO			
UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.		Fractured Left Hip.		3 weeks	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
march 1967		NO		no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		FELL OFF CHAIR AT HOME	
22. I certify that (I) (this hospital) attended the deceased from 7/7 1967 to 7/7 1967, that (I) (we) lost sight of the deceased alive on 7/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Leonard Kotz				7/7/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
LEONARD KOTZ.		11 Slade Ave #8 BALTO, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/10/67		Meadow Branch Cemetery Carroll Co, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 10 1967		Robert E. Taylor		Austin E. Donovan 3818 Roland Ave	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6547	
BIRTH NO. 67 6547		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA BIONDO		2. DATE AND HOUR OF DEATH 7/5/67 1:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 00 3930 PARK HEIGHTS AVE.		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 3930 PARK HEIGHTS AVE	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH APRIL 18, 1885	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH CATALANO		14. MOTHER'S MAIDEN NAME GOMELA PERONE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Mary Nardo - 3930 Park Heights Ave.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arthritis Deformans		CAUSE OF DEATH (A) Accident M. U. DUE TO (B) Arthritis Deformans DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 28 19 67 to 7/5/67 19 67 , that (I) (we) last saw the deceased alive on June 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester N. Kolman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/5/67	
23C. PHYSICIAN'S NAME (Type) LESTER N. KOLMAN		23D. ADDRESS M.D. 3700 Park Heights Avenue Balto Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-8-67	24C. NAME of CEMETERY or CREMATORY Catholic Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR ADDRESS Foley Company 2100 Canton St. Md.	

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6548	
BIRTH NO. <i>CONIBLER</i> 67 6548 CERTIFICATE OF DEATH					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>SISTER MARY ANGELA</i>				2. DATE AND HOUR OF DEATH <i>JULY 3, 1967</i> <i>11:45 AM.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 MERCY HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>HOWARD Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>ILCHESTER</i> D. STREET ADDRESS (If rural, give location) <i>63-00</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>9-8-1908</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TEACHER</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>RELIGIOUS</i>		11. BIRTHPLACE (State or foreign country) <i>PENN.</i>
13. FATHER'S NAME <i>EDWARD CONIBLER</i>			14. MOTHER'S MAIDEN NAME <i>MYRA KENNEDY</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. <i>212-58-8000</i>		17. INFORMANT <i>Kate Mary Muzich - Vellof Julie</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <i>Left Ventricular Failure</i> (B) DUE TO <i>Chronic Rheumatic Heart Disease</i> (C) <i>Anteroseptal Heart Disease</i>		
INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>20 yrs</i> <i>10-20 yrs</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sec</i> <i>1966</i> to <i>July</i> <i>1967</i> that (I) (we) last saw the deceased alive on <i>June</i> <i>1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Arlary T. O'Farrell</i>				23B. DATE SIGNED <i>7-3-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>ARLARY T. O'FARRELL</i>				23D. ADDRESS <i>5 CENTRAL AVE, GLEN BURNIE</i>	
24A. BURIAL CREMATION, REMOVAL (specify) <i>Burial</i>		24B. DATE <i>7-6-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Trinity Comfort Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Ilchester, Howard Co. Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 10 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>John Gorman</i>	
ADDRESS <i>John Gorman</i>					

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Arrived Seattle 10:00 AM
Left Seattle 10:00 AM

At 10:00 AM
Left Seattle 10:00 AM
Arrived Victoria 10:00 AM

Left Victoria 10:00 AM

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 6549	
BIRTH NO. 67 6549		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Martha H. Harms -XXXXXXXX		2. DATE AND HOUR OF DEATH 7-6-1967 3 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Belts Co.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00			
D. STREET ADDRESS (If rural, give location) 327 Fifth Ave. 21227							
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-3-87	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Herman Meyer				14. MOTHER'S MAIDEN NAME Anna Goehlert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. XXXXXXXXXXXX			
17. INFORMANT Mr. C. Walter Harms				ADDRESS 327 Fifth Ave. Lansdowne, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Acute Myocardial Infarction 11 hours				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4PM 7-5-1967 to 3AM 7-6-1967, that (I) (we) lost saw the deceased alive on 7-6-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Nguyen Thi Oanh				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-6-1967	
23C. PHYSICIAN'S NAME (Type) NGUYEN THI OANH				23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/67		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Hubbard Funeral Home		ADDRESS 4107 Wilkens Ave.	

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 6550				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6550	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Marie A. HASEK				2. DATE AND HOUR OF DEATH July 7, 1967 2:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 819 N. Chapel St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 7-05 D. STREET ADDRESS (If rural, give location) 819 N. Chapel St.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Nov. 13, 1880	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charwoman		10B. KIND OF BUSINESS OR INDUSTRY General Cleaning		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vaclav Hasek				14. MOTHER'S MAIDEN NAME Anna Balacek			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217 260 797A		17. INFORMANT Godfrey Hasek			ADDRESS 819 N. Chapel St.
18. 4341-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Angina Heart Failure Pul. Edema Liver Disease				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 15 19 67 to July 7 19 67 . that (I) (we) lost saw the deceased alive on July 6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Fred Ruzicka				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-8-67	
23C. PHYSICIAN'S NAME (Type) F. Frederick Ruzicka				23D. ADDRESS 800 N. ...			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE July 10, 1967		24C. NAME OF CEMETERY OR CREMATORY Bohemian National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Philip E. ...			

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mostly centered and spans most of the page width.]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
67. 6551					CERTIFICATE OF DEATH					Registered No. 67. 6551				
BIRTH NO.					M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>GIBSON, GEORGE T. A. Jr</u>					7/4/67, 9:35 AM.					M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)					A. STATE B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					<u>MARYLAND - 21216.</u>					<u>16-05</u>				
<u>46 LUTHERAN HOSPITAL OF MARYLAND.</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					<u>BALTIMORE</u>				
					D. STREET ADDRESS (If rural, give location)					<u>1005, Wheeler Ave.</u>				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
<u>MALE</u>		<u>NEGRO</u>		<u>MARRIED</u>		<u>3-22-16</u>		<u>51</u>						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)				
<u>Funeral Director</u>					<u>Self-employed</u>					<u>Baltimore, Md</u>				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
<u>U.S.A.</u>					<u>George T. A. Gibson, Sr</u>					<u>Edith A. Smith</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
										<u>Elinor B. Gibson, wife, 1005 W. Wheeler Ave</u>				
18. <u>743X1</u>					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) <u>A.S.H.C.V.D</u>									
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)					(B) <u>CVA & HEMIPLEGIA</u>									
ANTECEDENT CAUSES					(C) _____									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
<u>0</u>														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6-30-</u> <u>1967</u> to <u>7-4-</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>7-4-</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>Thankam B. Pillai</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>7/4/67</u>				
23C. PHYSICIAN'S NAME (Type) <u>THANKAM B. PILLAI</u>					M.D. <u>LUTHERAN HOSPITAL OF MARYLAND</u>									
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE					24C. NAME OF CEMETERY or CREMATORY				
<u>Burial</u>					<u>7-8-67</u>					<u>Arbutus Memorial Park</u>				
										24D. LOCATION (City, town, or county) (State)				
										<u>Arbutus, Balto. Co. Md.</u>				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR ADDRESS				
<u>JUL 10 1967</u>					<u>Robert E. Fisher, M.D.</u>					<u>John M. Johnson, 1700 Druid Hill Ave</u>				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6552	
67 6552				BIRTH NO.	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ANNIE SYKES			2. DATE AND HOUR OF DEATH 7-7-67 4:20 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1502		
5. SEX F			6. RACE N		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M
8. DATE OF BIRTH 2-12-06			9. AGE (In years last birthday) 61		10. CITIZEN OF WHAT COUNTRY? U.S.A.
11. BIRTHPLACE (State or foreign country) N. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jack Monk			14. MOTHER'S MAIDEN NAME Sarah		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Jimmie Sykes
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction			19. CAUSE OF DEATH 20 months after arrival at hospital		20. INTERVAL BETWEEN ONSET AND DEATH
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
23. DATE OF OPERATION		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No)	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
32. I certify that (I) (this hospital) attended the deceased from 7-7-67 to 7/7/67 19 67 to 7/7/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
33. SIGNATURE Sheikh Sheffnadin M.D.				34. DATE SIGNED 7-7-67	
35. PHYSICIAN'S NAME (Type) Sheikh Sheffnadin M.D.				36. ADDRESS Lutheran Hospital, MD	
37. BURIAL CREMATION, REMOVAL (Specify) Burial		38. DATE 7-12-67		39. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
40. LOCATION (City, town, or county) Baltimore, Maryland		41. STATE (State)			
42. DATE REC'D BY HEALTH DEPT. JUL 10 1967		43. NAME OF REGISTRAR Robert E. Faldut		44. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6553				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6553	
1. NAME OF DECEASED (Type or Print) McKinley George Dare				2. DATE AND HOUR OF DEATH July 7, 1967 1:35 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 15-01			
5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				8. DATE OF BIRTH 9-15-99		9. AGE (In years last birthday) 67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Alexander Dare			
14. MOTHER'S MAIDEN NAME Rachel				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 216100407				17. INFORMANT Mable Dare (Wife) 1529 Wood year St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus and infarct of right middle lobe.				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial fibrosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 21, 1967 to July 7, 1967 , that (I) (we) last saw the deceased alive on July 7, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. Laredo				23B. DATE SIGNED July 8, 1967			
23C. PHYSICIAN'S NAME (Type) C. Laredo		23D. ADDRESS 1514 Division St.					
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7-11-67		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Cem.		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Kelson Funeral Home		ADDRESS 1348 Calhoun St.	

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W-435

67. 6554

BALTIMORE CITY HEALTH DEPARTMENT

67. 6554

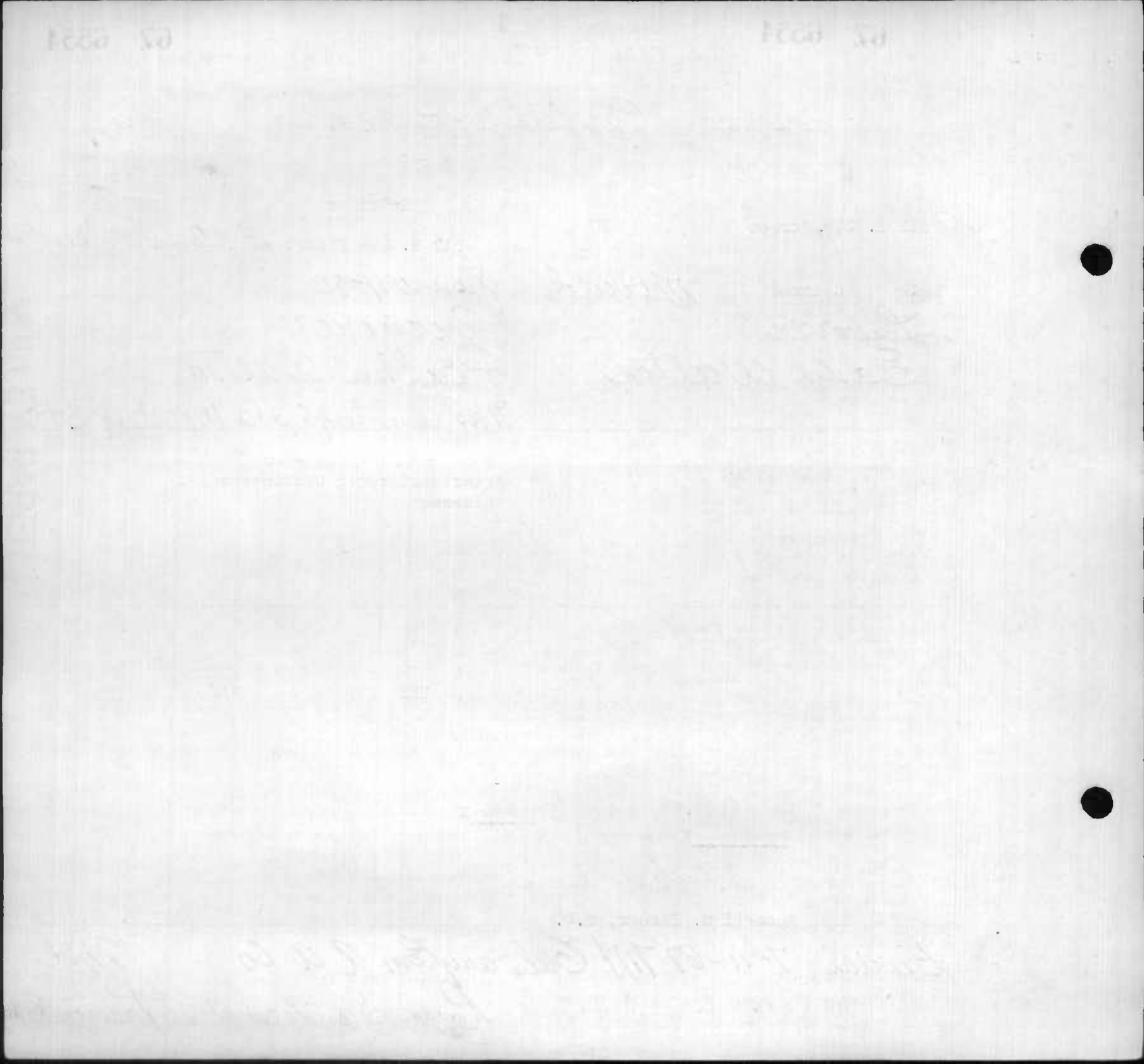
BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GARFIELD WALTON		2. DATE AND HOUR PRONOUNCED DEAD July 7, 1967 9:10 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 312 E. 20 1/2 Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 312 E. 20 1/2 Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
5. SEX Male		6. RACE Colored	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan 24 1920	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9. AGE (In years, last birthday) 48	
10B. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Eddie Walton		14. MOTHER'S MAIDEN NAME Peachie Walton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs Jennings 312 Worsley St	

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 I		(A) DUE TO	
		(B) DUE TO	
		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 8, 1967	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL, CREMATION, REMOVAL (Specify) Burial	23B. DATE 7-11-67	23C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem & A. Co	23D. LOCATION (City, town, or county) (State) Md
24A. DATE REC'D BY HEALTH DEPT. JUL 10 1967	24B. NAME OF REGISTRAR Russell S. Fisher	24C. FUNERAL DIRECTOR Raymond Sanders	ADDRESS 217 E Preston St



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

67. 6555

CERTIFICATE OF DEATH

Registered No. 67 6555

BIRTH NO. _____

M.E. CASE NO. Stern, Channing Jerrod

1. NAME OF DECEASED (Type or Print) CHANNING JERROD STERN

2. DATE AND HOUR OF DEATH 7-2-67 11:30A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL
33 BALTIMORE, MD 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1740 NORMAL AVE

5. SEX MALE 6. RACE NEGRO 7. MARRIED, NEVER MARRIED SINGLE 8. DATE OF BIRTH 9-26-58 9. AGE (In years last birthday) 8 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? _____

13. FATHER'S NAME RAYMOND STERN, SR. 14. MOTHER'S MAIDEN NAME EARLEAN RICHARDSON

15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Hospital Record ADDRESS _____

18. 722.01 CAUSE OF DEATH Possible Aspiration Pneumonia - 2 hrs
AND Possible Rheumatoid Pneumonia 2 wks
Rheumatoid Arthritis 2 mos

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH _____

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES _____

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____

19A. DATE OF OPERATION 6/30/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Dode Biopsy 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____ 21E. INJURY OCCURRED _____ 21F. HOW DID INJURY OCCUR? _____

22. I certify that (I) (this hospital) attended the deceased from June 14 19 67 to July 2 19 67, that (I) (we) last saw the deceased alive on July 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE H. Swick M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED July 2 1967

23C. PHYSICIAN'S NAME (Type) HERBERT SWICK M.D. 23D. ADDRESS JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7/6-67 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem 24D. LOCATION (City, town, or county) (State) R. A. Co. Md

25A. DATE REC'D BY HEALTH DEPT JUL 7 1967 25B. NAME OF REGISTRAR Rayner Sanders 25C. FUNERAL DIRECTOR Rayner Sanders ADDRESS 217 E Preston St

5 lbs Boiler Springs Boiler Springs
 5 lbs Boiler Springs Boiler Springs
 5 lbs Boiler Springs Boiler Springs

100 lbs Boiler Springs Boiler Springs Boiler Springs

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 6556		CERTIFICATE OF DEATH		Registered No. 67 6556		
1. NAME OF DECEASED (Type or Print) <u>Jeanette Hawkins</u>				2. DATE AND HOUR OF DEATH <u>7.5.67</u> <u>4:30 a.m.</u>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Bon Secours Hospital</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1846 22nd Fayette St</u>						
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>single</u>	8. DATE OF BIRTH <u>2.17.87</u>	9. AGE (In years last birthday) <u>80</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Waldorf Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Hawkins</u>			14. MOTHER'S MAIDEN NAME <u>Janie</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Hospital Record</u>				ADDRESS			
18. I <u>1551</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma, gall bladder</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>with wide spread metastases</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION										
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE AND HOW OLD INJURY OCCUR?		(If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <u>June 9, 1967</u> to <u>July 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 4, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Cesar A. Bravo</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>7/5/67</u>		
23C. PHYSICIAN'S NAME (Type) <u>CESAR A. BRAVO</u>				23D. ADDRESS <u>BON SECOURS HOSPITAL</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-8-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Calvary Em. C. A. Co</u>		24D. LOCATION (City, town, or county) (State) <u>MD</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley</u>		25C. FUNERAL DIRECTOR <u>Raymond S. Sanders</u>						
ADDRESS <u>217 E. Preston St</u>										

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San Francisco Hospital

George W. Hanks

George W. Hanks

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67. 6557					Registered No. 67. 6557					
CERTIFICATE OF DEATH										
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					JOHN JESSUP			4 July 67 1 7 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE Md					
UNIV. OF MARYLAND HOSP					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto city					
38					D. STREET ADDRESS (If rural, give location) 632 Pitcher St					
5. SEX M		6. RACE Neg		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower		8. DATE OF BIRTH 5/8/87		9. AGE (In years last birthday) 80		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Jessup					14. MOTHER'S MAIDEN NAME Nancy Taylor					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Chant			
18. 332 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) STROKE DUE TO (B) MCA Thrombosis DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0										
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 15 June 19 67 to 4 July 19 67 that (I) (we) last saw the deceased alive on 4 July 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Stanley Music					M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 4 July 67		
23C. PHYSICIAN'S NAME (Type) STANLEY MUSIC M.D.					23D. ADDRESS % Univ. Hosp					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/67		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetry		24D. LOCATION (City, town, or county) (State) A A County Md				
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Jenkins			25C. FUNERAL DIRECTOR Adolphus Halstead					
ADDRESS 1206 W North Ave										

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6558	
67 6558				67 6558	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) FAULKNER, BEYLAH				7/7/67 648 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hosp		A. STATE md.		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		8-06	
5. SEX F		6. RACE N		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		9. AGE (In years last birthday) 43		10. DATE OF BIRTH May 5, 1924	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
13. FATHER'S NAME Alex Stokes		14. MOTHER'S MAIDEN NAME Rosa		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Rosa Mason	
				ADDRESS 1723 Homestead St	
18. 260 X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DIABETIC KETOACIDOSIS			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7/7 19 67 to 7/7 19 67 , that (I) (we) last saw the deceased alive on 7/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Kurt P. Sligar		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) KURT P. SLIGAR		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/67		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR William G. March	
				ADDRESS 928 E. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67. 6559		CERTIFICATE OF DEATH		Registered No. 67. 6559	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				FRANKLIN H. BURKE Sr.		7-9-67 14:58 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
MARYLAND GENERAL HOSP		48		Md.		B. ANNE ARUNDEL Co.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				Linthicum Hgts		52-00			
				D. STREET ADDRESS (If rural, give location)					
				114 N HAMMOND					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months Days	
Male	W.	MARRIED		6-20-91		76			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Ret. (RAILROAD)		TRANSPORTATION		Md.		USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
DAVID				Georgette BARRETT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes		UNK.		216-01-2473		Wife (Grace Burke)		Same as Dec.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
				(A) Myocardial Infarction				1 week	
				(B) Coronary artery occlusion					
				(C) Arteriosclerotic CVDisease					
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
NONE				Yes		yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
No		NONE							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (1) (this hospital) attended the deceased from 7-3 19 67 to 7-9 19 67, that (1) (we) last saw the deceased alive on 7-9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
Frank J. Zwick						7-9-67			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
						M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		7/12/67		Loudon Park		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 10 1967		Robert S. Taylor		Wm. Cook-Brooks Inc.		Baltimore, Md. 21202			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6560	
BIRTH NO. 67 6560		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH July 7, 1967 10:20 P.M.	
1. NAME OF DECEASED (Type or Print) William Harvey Campbell		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 25 West Chase Street, Apt A1	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH March 11, 1908
9. AGE (In years last birthday) 59		10. CITIZEN OF WHAT COUNTRY? U.S.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager		10B. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William T. Campbell		14. MOTHER'S MAIDEN NAME Margaret Harvey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Admission History Sheet		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Coronary Occlusion 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) Arteriosclerotic Heart Disease 20 years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Palmonary Embolus	
20A. AUTOPSY (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Home		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) June 22 1967	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? M. Newman	
22. I certify that (the) (this hospital) attended the deceased from June 22 1967 to July 7 1967 , that (I) (was) last saw the deceased alive on July 7 1967 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Bruce E. Cathey		23B. DATE SIGNED July 8, 1967	
23C. PHYSICIAN'S NAME Bruce E. Cathey		23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/67	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Catonsville, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.		ADDRESS Baltimore, Md. 21202	

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10-30-9

July 7, 1967

William Harvey Campbell

Maryland
Baltimore

22 West Chase Street, Apt. A1

Union Memorial Hospital

Male White Never married March 11, 1929

Office Manager Insurance Brooklyn, N.Y. U.S.

William T. Campbell Margaret Harvey

Unknown Admission History Short

~~Myocardial Infarction 2 days~~

~~Coronary Occlusion 3 days~~

~~Arteriosclerotic Heart Disease 20 years~~

~~Pulmonary Embolus 3 days~~

~~1/2 1/2~~

July 7 June 22 July 7

July 8, 1967

Union Memorial Hospital

Bruce E. Cathey
Bruce E. Cathey

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6561	
<div style="display: flex; justify-content: space-between;"> 67 6561 CERTIFICATE OF DEATH 67 6561 </div>											
<div style="display: flex; justify-content: space-between;"> <div> 1. NAME OF DECEASED (Type or Print) <u>Tingley, Mrs. Helen C.</u> </div> <div> 2. DATE AND HOUR OF DEATH <u>7-8-67</u> <u>10⁴⁵</u> a. M. </div> </div>											
3. PLACE OF DEATH <u>Baltimore, Maryland</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY _____					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>911 Keswick</u>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>					
						D. STREET ADDRESS (If rural, give location) <u>700 W. 40th. St.</u>					
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED <u>WIDOWED</u> DIVORCED (specify)		8. DATE OF BIRTH <u>Dec. 4, 1894</u>		9. AGE (In years last birthday) <u>72</u>		If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director - Public Relations Mental Hygiene</u>						10B. KIND OF BUSINESS OR INDUSTRY <u>MD. State Dept. -</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>											
13. FATHER'S NAME <u>John Judson Curley</u>						14. MOTHER'S MAIDEN NAME <u>Coro Chenoweth</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>						16. SOCIAL SECURITY NO. <u>226-186794</u>		17. INFORMANT <u>Mary B. DiPaola R.N.</u> ADDRESS _____			
18. CAUSE OF DEATH <u>331 XI</u>											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular accident Hours</u>											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized arteriosclerosis Years</u>											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1964</u> 19<u>64</u> to <u>July 8</u> 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>July 8</u> 19<u>67</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>RK Gundry</u> M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										23B. DATE SIGNED <u>7-8-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>RK Gundry</u> M.D.						23D. ADDRESS <u>2 W University Pkwy - 21218</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>7-11-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>				24D. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1967</u>				25B. NAME OF REGISTRAR <u>Reuben E. Farley, MD</u>				25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 Yrok Rd. Balto., Md.</u>			

1960

1

1960



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6562	
67 6562				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KNELLER, Mr BURTRAM I	
2. DATE AND HOUR OF DEATH 7/7/67 12:25 M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 48			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY —		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 757 McKewin Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 12/15/82	9. AGE (In years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Bus Driver Balto. Transit Co		10B. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HENRY Kneller			
14. MOTHER'S MAIDEN NAME EVA GRAF		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			
16. SOCIAL SECURITY NO. 214 03787		17. INFORMANT Nettie Kneller ADDRESS SAME AS DECEASED			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 602X		CAUSE OF DEATH (A) Uremia DUE TO (B) Nephritis DUE TO (C) Renal Calculi		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month 17 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Anemia					
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6-21 19 67 to 7-7 19 67 . that (X) (we) last saw the deceased alive on 7-6 19 67 and that in (my) (Dr.) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank J. Zorich M.D.				23B. DATE SIGNED 7-7-67	
23C. PHYSICIAN'S NAME (Type) Dr. Frank J. Zorich M.D.		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967			
25B. NAME OF REGISTRAR Robert E. Fidler		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 21212 4905 York Road Baltimore, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200		67. 6563		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6563	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Boyce, Rebecca Lotimer		7/7/67 3:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
44 The Union Memorial Hospital				Md. Baltimore City			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 27-14			
D. STREET ADDRESS (If rural, give location)							
7 Elmhurst Road							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)		
F	Cauc		3/3/10	57	Md.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?			
Unemployed		-		U.S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Heyward A. Boyce				A mabel George			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		214-16-3048		John C.G. Boyce		Balto., Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
581.1 I				Fat embolism, phlebitis of liver			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
				Heart failure			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				chronic alcoholism			
				Congestive heart failure			
				(C) Alcoholism			
				W.K.W.			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
7/4/67		Respiratory distress		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/3 1967 to 7/7 1967, that (I) (we) last saw the deceased alive on 7/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Barry J. Weckesser				7/7/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
BARRY J. WECKESSER, M.D.				THE UNION MEMORIAL HOSPITAL			
				24 East Eager St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-10-67		Green Mount Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 10 1967		Robert E. Farkas, M.D.		H. W. Jenkins & Sons Co.		21212	
				4905 York Road Balto., Md.			

Boyle, Rebecca

The Union Memorial Hospital

Unemployed
F Care

Howard A Boyle

Md Baltimore
REINBURSEMENT ROAD

Md

A mabel George

~~Getchell's m~~
~~Constance Kent Taylor~~
~~Heart failure~~
~~Heart failure~~

Residence given

11/1/12

Grandmother Boyle

at Central St

11/1/12

✓

11/1/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 6564

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Elizabeth Hopkins Reip

2. DATE AND HOUR OF DEATH

7-6-1967

9:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

If not in hospital or institution, give street
address or location

5415 The Alameda

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5415 The Alameda

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11-6-1881

9. AGE (In years
lost birthday)

85

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Newfoundland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Hopkins

14. MOTHER'S MAIDEN NAME

Hopkins

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

—

17. INFORMANT

Mrs. B. J. Hayman

ADDRESS

Same

18. 443 X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

*Hypertensive cardiac-vascular
disease*

INTERVAL BETWEEN
ONSET AND DEATH

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diverticulitis, sigmoid colon

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

that (I) (we) last saw the deceased alive on

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

Dr. J. W. Barnaby

M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

7 July 1967

23D. ADDRESS

M.D.

1531 E. North Avenue Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-10-67

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore,

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 10 1967

R. E. Taylor, M.D.

H. W. Jenkins & Sons Co. 21212
4905 York Road Balto. Md.

Effort was made to
secure

But it is again clear

that the
effort was

John W. ...

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6565

BIRTH NO. 67 6565

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES C. HENSON

2. DATE AND HOUR PRONOUNCED DEAD

7-5-67

6:40 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1235 Division Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

M

8. DATE OF BIRTH

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Julia Henson, same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

420.0 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

CHARLES S. SPRINGATE, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-6-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/10/67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

JUL 10 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

RECEIVED



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6566	
BIRTH NO. 67 6566		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 7/6/67 12:30 A.M.			
1. NAME OF DECEASED (Type or Print) FELTON, Rose					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION 90 George Washington Carver Nursing Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 14-02			
		D. STREET ADDRESS (If rural, give location) 1700 Eutan Place apt. 1A			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH UNKNOWN	9. AGE (In years last birthday) 100	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) UNKNOWN	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Chm # 413	
18. 443 XI		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebro vascular accident		INTERVAL BETWEEN ONSET AND DEATH Jan 1965	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertension arteriosclerotic			
		(C) Ischemic		2 yrs.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5/67 9/8 19 61 to 7/6 19 67 , that (I) (we) last saw the deceased alive on 7/5/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.N. Mac Murchy				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) 25 J.N. Mac Murchy				23D. ADDRESS 2500 Garrison Blvd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md					
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	

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1. NAME OF DECEASED (Type or Print) **CHARLENE CRAWFORD** 2. DATE AND HOUR PRONOUNCED DEAD **July 3, 1967 4:03 P. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **SOUTH BALTIMORE HOSPITAL** 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
 A. STATE **Maryland** B. COUNTY **Baltimore**
 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
 D. STREET ADDRESS (If rural, give location) **3432 Chessel Ct.**

5. SEX **Female** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Baby** 8. DATE OF BIRTH **6/18/67** 9. AGE (In years last birthday) **14** 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Baby** 11. BIRTHPLACE (State or foreign country) **Baltimore Maryland** 12. CITIZEN OF WHAT COUNTRY? **U S A**

13. FATHER'S NAME **Charles Vines** 14. MOTHER'S MAIDEN NAME **Francis Crawford** 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **no** 16. SOCIAL SECURITY NO. 17. INFORMANT **Mother**, same ADDRESS

18. CAUSE OF DEATH
 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH **Interstitial Pneumonitis (SDII)**
 (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **Yes** 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Noturol causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined monner ☐

ACTUAL SIGNATURE **Werner U. Spitz, M.D.** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **7/4/67**
 EXAMINER'S NAME (Type) **Werner U. Spitz, M.D.** ASSISTANT MEDICAL EXAMINER ☒
 ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **7/8/67 Burial** 23B. DATE **7/8/67** 23C. NAME of CEMETERY or CREMATORY **Mt. Auburn Cemetery** 23D. LOCATION (City, town, or county) (State) **Baltimore Md**

24A. DATE REC'D BY HEALTH DEPT. **JUL 10 1967** 24B. NAME OF REGISTRAR **Robert E. Farley** 24C. FUNERAL DIRECTOR **Adolphus Halstead** ADDRESS **1206 W North Ave**

VS 151-REV. 1/1/65

WILLIAM
B. WILSON
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WILLIAM B. WILSON

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

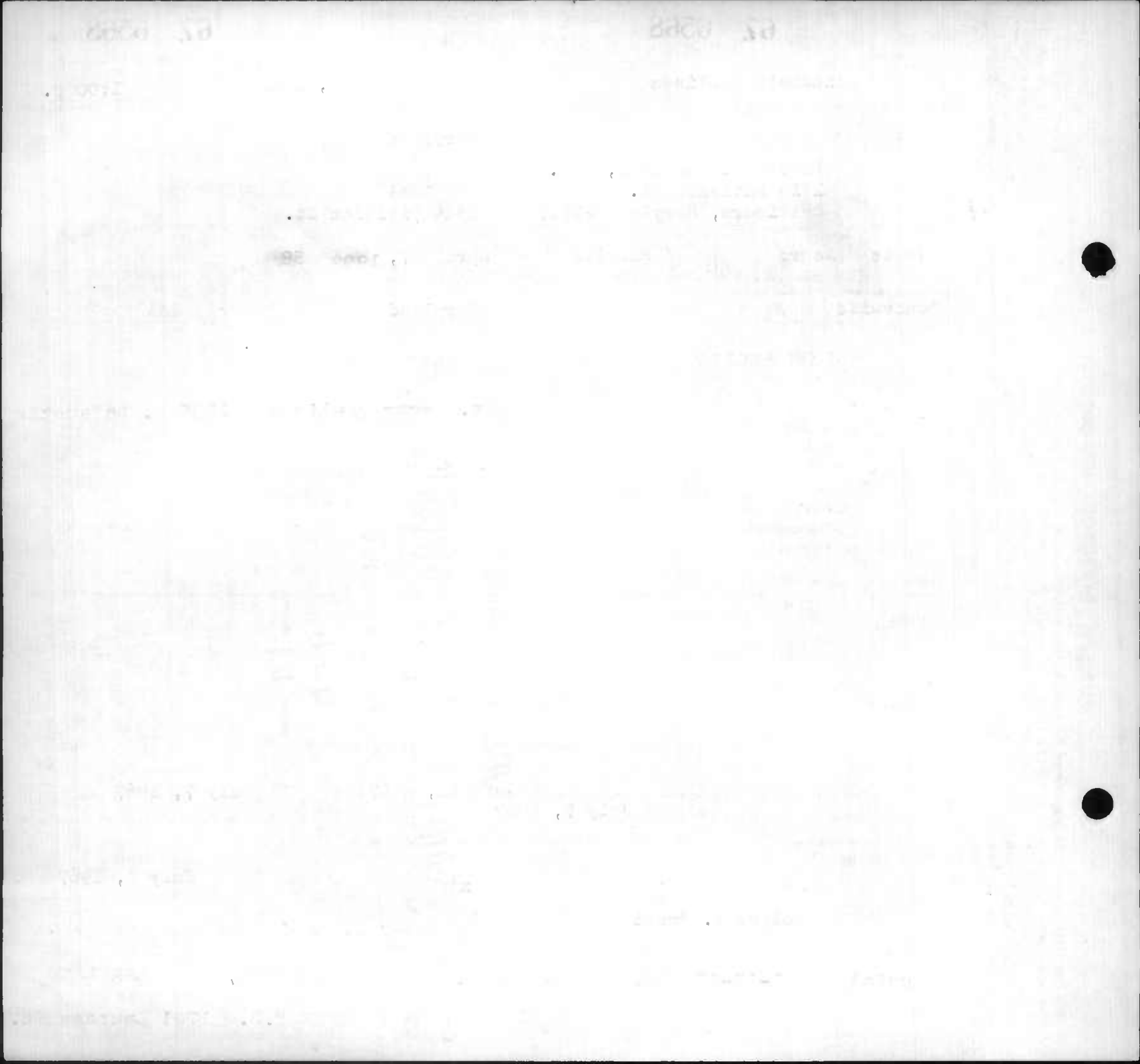
R-4512

67 6568

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 6568

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Elizabeth Rawlings		2. DATE AND HOUR OF DEATH July 7, 1967 1:00 p. m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1514 Division St.			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 27, 1909	9. AGE (In years) (at birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME JOHN ANDERSON			14. MOTHER'S MAIDEN NAME MARY ANDERSON		12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Oscar Rawlings 1805 W. Lafayette			
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cerebral Thrombosis & Septic Hemiplegia (B) Septic Intermittent (C)		INTERVAL BETWEEN ONSET AND DEATH 4 wks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia				3 days			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 23, 1967 19 to July 7, 1967 19, that (I) (we) last saw the deceased alive on July 7, 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Roland T. Smoot M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 8, 1967	
23C. PHYSICIAN'S NAME (Type) Roland T. Smoot				23D. ADDRESS M.D. 3817 Gay St. Bldg 15			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-10-67	24C. NAME OF CEMETERY or CREMATORY MOUNT AUBURN CEM.		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6569	
BIRTH NO. 67 6569		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RANDOLPH, John (NMI)		2. DATE AND HOUR OF DEATH July 7, 1967 11:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 27 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		D. STREET ADDRESS (If rural, give location) 4230 Norfolk Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/10/1888	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor (retired)		10B. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Fluvoria, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Willis Randolph		14. MOTHER'S MAIDEN NAME Jain Payne	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes 10/27/17-3/29/18		16. SOCIAL SECURITY NO. 218-20-0662		17. INFORMANT ADDRESS VA Hospital Records, Baltimore, Md. 21218	
18. 446X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Uremia		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) arteriolar nephrosclerosis DUE TO		4 months	
(C) chronic renal infection					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Epididymo orchitis Benign Prostatic Hypertrophy, Blind			
19A. DATE OF OPERATION 6/22/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED epididymo orchitis		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 23rd 1967 to July 7th 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 7th 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.			
23A. SIGNATURE Edward Hunt		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/7/67	
23C. PHYSICIAN'S NAME (Type) EDWARD HUNT		23D. ADDRESS 3900 Loch Raven Boulevard VA Hospital, Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) 5501 Frederick Rd., Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR ADDRESS Morton & Dyatt Funeral Home 1701 Laurens St					

Case No.

Case No.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67. 6570		67. 6570		67. 6570	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		THERESA MARIE LUTCHE (MRS SAMUEL)		JULY 10, 1967 3:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE BALTO MARYLAND			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
44		D. STREET ADDRESS (If rural, give location) 3709 ALAMEDA CIRCLE #18			
5. SEX Female	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 07-04-85	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) GERMANY	
13. FATHER'S NAME WINDERLAND ROTH		14. MOTHER'S MAIDEN NAME ROSALIE (UNKNOWN)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MRS NAOMI ERNA WELLEIN	
				ADDRESS 3709 ALAMEDA CIRCLE BALTO, MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 331 X I		CAUSE OF DEATH (A) CEREBRO VASCULAR ACCIDENT DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH 11 hours			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		ACUTE PULMONARY EDEMA			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 9th 1967 to July 10th 1967, that (I) (we) lost saw the deceased alive on July 10th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Miguel R. Sanchez-Palacios				23B. DATE SIGNED July 10th, 1967	
23C. PHYSICIAN'S NAME (Type) MIGUEL R. SANCHEZ-PALACIOS				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/67		24C. NAME OF CEMETERY OR CREMATORY 1st German United Evang.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6571	
<div style="display: flex; justify-content: space-between;"> 5-402 67 6571 CERTIFICATE OF DEATH </div>					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Slee, Mrs. Mary E.	
2. DATE AND HOUR OF DEATH July 7, 1967		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 "KESWICK"			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		8. DATE OF BIRTH October 15, 1889 9. AGE (In years, month, day) 77			
D. STREET ADDRESS (If rural, give location) Keswick-- 2767 Tivoly Avenue		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Mathiesen		14. MOTHER'S MAIDEN NAME Katherine Michel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-4156		17. INFORMANT Miss Helen Keler R.N.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 hrs. 2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8 June 1966 to 7 July 1967 , that (I) (we) last saw the deceased alive on 7 July 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE Aubrey D. Richardson				23B. DATE SIGNED 9 July 1967	
23C. PHYSICIAN'S NAME (Type) Aubrey D. Richardson,				23D. ADDRESS 700 W. 40th Street Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/67.		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967			
25B. NAME OF REGISTRAR Alfred E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		25D. ADDRESS Balto. Md. 21214	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6572</u>	
BIRTH NO. <u>67 6572</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Cecilia Maginnis</u>		2. DATE AND HOUR OF DEATH <u>July 9, 1967</u> <u>1:00 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mercy Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
D. STREET ADDRESS (If rural, give location) <u>3016 Evergreen Ave.</u>		E. STREET ADDRESS (If rural, give location) <u>3016 Evergreen Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct 27, 1900</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Clerk (Ret.) Tele. Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Thomas Mackessy</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mullen</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Carroll Mackessy 3016 Evergreen Ave.</u>	
18. <u>150X I</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>CHF of pulmonary effusion</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Leukoplakia x° to ca of esophagus, metastasizing to brain, lungs, uterus.</u>			
		(C) <u>Generalized metastasis x° to carcinoma</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>Hysterect. 10/9/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca, uterus</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-27</u> <u>1967</u> to <u>7-9</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>7-9</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Maria Y. Que</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-9-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Maria Y. Que</u>		23D. ADDRESS <u>Mercy Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/12/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Feltman</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, inc. 5305 Harford Rd.</u>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6573	
BIRTH NO. 67 6573		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George D. Grimm		2. DATE AND HOUR OF DEATH 10 July 1967 16:20 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE 42		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 6697 BIRCHWOOD AVE 21214			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-19-1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Tile Setter		10B. KIND OF BUSINESS OR INDUSTRY Tile		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Grimm		14. MOTHER'S MAIDEN NAME Adelaide Market			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Helen M. Grimm-- Same	
18. 154 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) FLUID & ELECTROLYTE IMBALANCE DUE TO (B) INTESTINAL OBSTRUCTION DUE TO (C) CARCINOMA OF THE RECTUM METASTATIC FROM PROSTATE II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. SENILITY		INTERVAL BETWEEN ONSET AND DEATH UNDETERMINED			
19A. DATE OF OPERATION 6-28-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA, RECTUM		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that WE (this hospital) attended the deceased from JULY 3 1967 to JULY 10 1967 , that (I) (we) last saw the deceased alive on JULY 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eulogio O. Bonsukan				23B. DATE SIGNED 10 July 1967	
23C. PHYSICIAN'S NAME (Type) EULOGIO O. BON SUKAN				23D. ADDRESS SINAI HOSP, BALTO MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/67		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd. #1			

1500 - 15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6574	
67 6574 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or print) William S. Lauer.				July 8, 1967 10:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.			A. STATE Baltimore.		
CITY OR TOWN (If outside city limits, write RURAL and give township) Maryland.			D. STREET ADDRESS (If rural, give location) 6101 Loch Raven Blvd.		
5. SEX Male.	6. RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower.	8. DATE OF BIRTH 1/17/1894	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Manager		10B. KIND OF BUSINESS OR INDUSTRY Fertilizer		11. BIRTHPLACE (State or foreign country) Baltimore.	
13. FATHER'S NAME Steven Lauer.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 160-01-2975A		17. INFORMANT William E. Lauer, 3307 Crossland Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOCLEROTIC VASCULAR DISEASE			CAUSE OF DEATH CHANGES OF THE LIVER		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 5 YEARS		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 14, 1965 to July 8th, 1967 , that (I) (we) last saw the deceased alive on July 8, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Luis J. Elias				23B. DATE SIGNED 7/10/67	
23C. PHYSICIAN'S NAME (Type) Luis J. Elias				23D. ADDRESS 1701 Meridene Drive.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/67		24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE RECEIVED BY HEALTH DEPT. JUL 16 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonardo J. Ruck, inc. 5305 Harford Rd.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6575

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 6575

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARY L. Fox

2. DATE AND HOUR OF DEATH

JULY 9, 1967 10 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

LITTLE SISTERS OF THE POOR

1200 VALLEY STREET

BALTIMORE, MARYLAND 21202

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1200 VALLEY STREET

5. SEX

F

6. RACE

W

7. MARRIED, ~~NEVER MARRIED~~
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

AUG. 17, 1888

9. AGE (In years
last birthday)

78

If Under 1 Yr. II Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

NURSEMAID

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

TIMOTHY Fox

14. MOTHER'S MAIDEN NAME

MARGARET Mc NULTY

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)
No16. SOCIAL
SECURITY NO.

215-42-1428A

17. INFORMANT

ADDRESS
LITTLE SISTERS OF THE POOR 1200 VALLEY ST.
BALT, MD. 21202

18. 420.11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Acute coronary Thrombosis

(B) DUE TO

Q.S.C.V.D.

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1966 to 7.9. 1967.
that (I) (we) lost saw the deceased alive on 7.9. 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stanley Ankudas

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

7.10.67

23C. PHYSICIAN'S
NAME (Type)

STANLEY ANKUDAS

M.D.

23D. ADDRESS

1101 MAIDEN CHOICE LANE, BALT, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 10 1967

25B. NAME OF REGISTRAR

Robert E. Fickema

25C. FUNERAL DIRECTOR

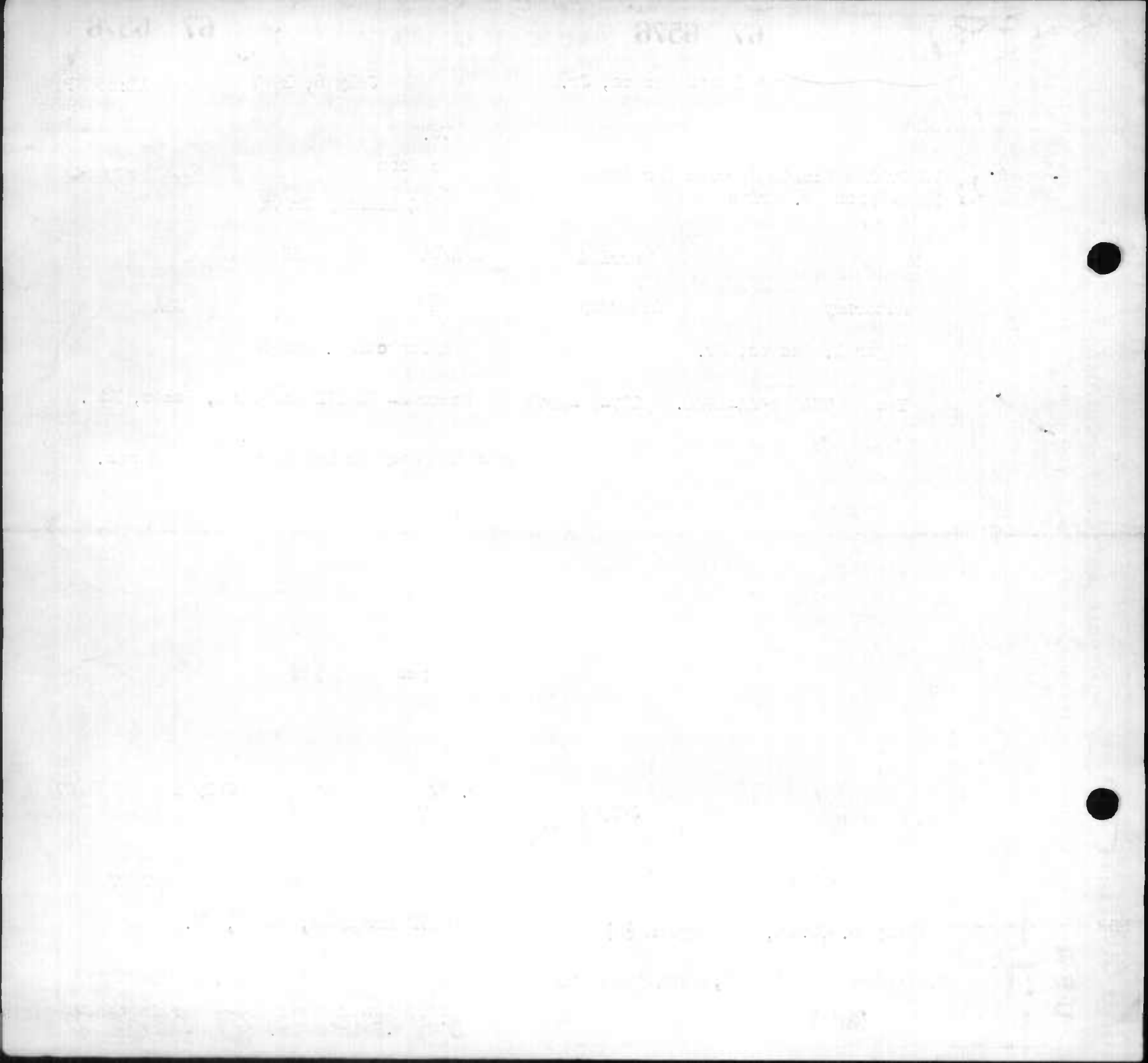
Funeral Home, 1422 Light St.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6576	
BIRTH NO. 67 6576		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edgar Thomas Reeves, Jr.		2. DATE AND HOUR OF DEATH July 6, 1967 12:15 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Pk. Drive			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Mc Lean D. STREET ADDRESS (If rural, give location) 1954 Kennedy Drive		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/4/09	9. AGE (In years last birthday) 58	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10B. KIND OF BUSINESS OR INDUSTRY Attorney		11. BIRTHPLACE (State or foreign country) NC	
13. FATHER'S NAME Edgar T. Reeves, Sr.			14. MOTHER'S MAIDEN NAME Elizabeth W. Waugh		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1944-1946.		16. SOCIAL SECURITY NO. 227-36-1571		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute lymphocytic leukemia (A) DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 8 mos.		
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Apr. 24 1967 to July 6 1967 , that (I) (we) last saw the deceased alive on July 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry S. Crist M.D.				23B. DATE SIGNED 7/7/67	
23C. PHYSICIAN'S NAME (Type) Henry S. Crist, SA Surgeon (R)			23D. ADDRESS US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE July 7, 1967		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
24D. LOCATION Suitland, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Fulkerson		25C. FUNERAL DIRECTOR Arlington Funeral Home 3901 N. Fairfax Dr. <i>David H. Cawell</i>	



THE REMAINS OF GOLDEN LEE WERE RELEASED TO THE FUNERAL DIRECTOR: IMPORTANT APPROVAL DR. LINTHICUM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 6577	
BIRTH NO. 67 6577		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) LEE (LAST) GOLDEN (FIRST) LEE, Golden			2. DATE AND HOUR OF DEATH July 8 th 1967 6:30 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital 33			A. STATE MD		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 7-04		
			D. STREET ADDRESS (If rural, give location) 1014 N. WOLFE ST.		
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-30-03	9. AGE (In years lost birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Benton N. C.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME NATHAN E. LEE			14. MOTHER'S MAIDEN NAME ELIZA LANE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Grover Lee		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES			(A) Alcoholic withdrawal syndrome & seizures		7 days?
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Megaloblastic anemia & severe pancytopenia.		Weeks
			(C) Aspiration pneumonia		2 days?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 7 th 1967 to July 8 th 1967, that (I) (we) last saw the deceased alive on July 8 th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard H. Winterbauer M.D.				23B. DATE SIGNED July 8 th , 1967	
23C. PHYSICIAN'S NAME (Type) Richard H. Winterbauer M.D.				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 10/67		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem	
				24D. LOCATION (City, town, or county) (State) A. A. County Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Fred E. Glickman 15977 Cuthbert	

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U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67. 6578					67. 6578				
BIRTH NO.					Registered No.				
M.E. CASE NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) Robert Lee (Jones) Knight					2. DATE AND HOUR OF DEATH July 10, 1967 5:30 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 306 E. Lomvale St.					A. STATE Maryland				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
00					D. STREET ADDRESS (If rural, give location) 306 E Lomvale St.				
5. SEX Male	6. RACE Cal	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH June 25, 1907	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Ose Knight					14. MOTHER'S MAIDEN NAME Indiana Jones				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-10-4784		17. INFORMANT Indiana Knight				
					ADDRESS Buckeville, Va				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Stomach					INTERVAL BETWEEN ONSET AND DEATH 1 year				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. None									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None									
19A. DATE OF OPERATION May 28, 1967			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Stomach		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from July 1, 1967 to July 10, 1967 , that (I) was last saw the deceased alive on July 6, 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.									
23A. SIGNATURE Jay N. Karpa M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/10/67		
23C. PHYSICIAN'S NAME (Type) Jay N. Karpa					23D. ADDRESS 3502 W. Rogers Ave.				
24A. BURIAL CREMATION, REMOVAL (Specify) General			24B. DATE July 14/67		24C. NAME OF CEMETERY or CREMATORY Lunenburg City Va.		24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1967			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Sparks T. Ellickson 1129 N. Calhoun St.				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6579	
BIRTH NO. 67 6579		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ella Akehurst		2. DATE AND HOUR OF DEATH July 7 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
90 Hillcrest Nursing Home		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore		13-06	
		D. STREET ADDRESS (If rural, give location)			
		3522 Elm Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Nov. 10 1873	9. AGE (In years last birthday) 93	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home
		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Phillip Hare		14. MOTHER'S MAIDEN NAME Isabell Alban			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Jane Lillich 3522 Elm Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Cancer of the breast		INTERVAL BETWEEN ONSET AND DEATH 4 years	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1st 1965 to July 7 1967, that (I) (we) last saw the deceased alive on June 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Luis J. Elias		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 8 1967	
23C. PHYSICIAN'S NAME (Type) Luis J. Elias		23D. ADDRESS M.D. Northern PKwy - Loch Raven Blvd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 10 1967		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
		24D. LOCATION (City, town, or county) (State) Pikesville, Maryland			
25A. DATE REC'D BY HEALTH DEPT JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Burge Funeral Home 3631 Falls Rd. 6510 Lynn Burge Henss	

General of the West

June 22 1864

For the West

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6580	
BIRTH NO. 67 6580		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JORDAN SAMUEL		2. DATE AND HOUR OF DEATH 7. 7. 67 3.55 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		A. STATE MD. B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO			
		D. STREET ADDRESS (If rural, give location) 2019 W. NORTH AVE			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5.23.93	9. AGE (In years last birthday) 74	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Samuel Jordan		14. MOTHER'S MAIDEN NAME Cora Bakery		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Augusta Jordan		ADDRESS 2019 W. North Ave	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis		CAUSE OF DEATH (A) DUE TO A.S.C.V.D. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-4-67 to 7-7-67 , that (I) (we) last saw the deceased alive on 7-7-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Milos Radojkovic		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-7-67	
23C. PHYSICIAN'S NAME (Type) MILOS RADOJKOVIC		23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-11-67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem	
				24D. LOCATION (City, town, or county) (State) Balto - Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Robert A. Johnson	
				ADDRESS 1804 McCulloch	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6581		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6581	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Thomas E. Steinhice		2. DATE AND HOUR OF DEATH 7-8-67 9:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY A.A.C.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) McGlen Burnie	
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 105 ALLEN Rd.	
5. SEX M.	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-17-1913	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Post Office Mail Carrier		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas J. Steinhice		14. MOTHER'S MAIDEN NAME Ada Waible	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II 1945		16. SOCIAL SECURITY NO. 220-079879		17. INFORMANT Mrs. Joyce Steinhice	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 204.41		CAUSE OF DEATH (A) Force etiology undetermined DUE TO (B) Probable leukemia DUE TO (C)		ADDRESS 105 Allen Rd. INTERVAL BETWEEN ONSET AND DEATH 1 month	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		II			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 6-14 19 67 to 7-8 19 67 , that the (we) last saw the deceased alive on 7-8 19 67 , and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Samadi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-10-67	
23C. PHYSICIAN'S NAME (Type) A. Samadi		23D. ADDRESS 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR McGlen Burnie Funeral Home		ADDRESS 237 Ratapasco		21225	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6582 CERTIFICATE OF DEATH					Registered No. 67 6582				
BIRTH NO.					2. DATE AND HOUR OF DEATH				
M.E. CASE NO.					July 9, 1967 13:30 P. M.				
1. NAME OF DECEASED (Type or Print)					3. PLACE OF DEATH IN BALTIMORE, MARYLAND				
ROSAMAE FOWLER					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 215 E. Cross St. 00					A. STATE Md.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21230 24-03				
D. STREET ADDRESS (If rural, give location) 215 E. Cross St.					5. SEX F				
					6. RACE W				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed					8. DATE OF BIRTH Jan. 22, '03				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					9. AGE (in years last birthday) 64				
10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Calvert Co., Md.				
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME James F. Fowler				
14. MOTHER'S MAIDEN NAME Emma Florence Buckler					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO.					17. INFORMANT Mr. Albert Fowler 1727 Jackson St.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) Myocardial infarction DUE TO (B) Atherosclerotic heart DUE TO Hypertension (C)				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1966 to July 1967, that (I) (we) last saw the deceased alive on July 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ricardo Lopez					23B. DATE SIGNED 7/10/67				
23C. PHYSICIAN'S NAME (Type) RICARDO LOPEZ					23D. ADDRESS M.D. 1228 S. Charles St. B. H. H. 21230				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7/12/67				
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.					24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967					25B. NAME OF REGISTRAR Robert E. Farber				
25C. FUNERAL DIRECTOR JOHN F. DENNY, INC.					25D. ADDRESS 715 Light St.				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67. 6583	
67. 6583 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) JEAN HARNER CLAPSADLE		8 July 67 12 noon			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Union Memorial Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY Baltimore Co.			
5. SEX F		6. RACE CO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 2/13/31		9. AGE (In years last birthday) 36		10. If Under 1 Yr. Months: Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles A. Harner			
14. MOTHER'S MAIDEN NAME Anna Louise Hartman		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT 227 Dawson Road Arthur B. Clapsaddle Cockeysville MD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 330XI		CAUSE OF DEATH Interval between ONSET AND DEATH Dissected Aortic Hemorrhage Ruptured Berry Aneurysm Status post tie-off of Berry Aneurysm - 6 days. M. Newman			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 7/3/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (R) BERRY ANEURYSM		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 June 1967 to 8 July 1967 , that (I) (we) last saw the deceased alive on 8 July 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8 July 67	
23C. PHYSICIAN'S NAME (Type) EDWARD J. FLYNN		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-1967		24C. NAME OF CEMETERY or CREMATORY Hillcrest Memorial Gardens	
24D. LOCATION (City, town or county) (State) Cockeysville, Adams Pa		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967			
25B. NAME OF REGISTRAR R. G. E. Farkas		25C. FUNERAL DIRECTOR Edmund F. Peters			
25D. ADDRESS 321 Cordiale Rd		Cockeysville, Pa.			

554

$$c = 2$$

Paul + Rose
and family

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67. 6584

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM H. HUGHES

2. DATE AND HOUR PRONOUNCED DEAD

July 8, 1967

12:40 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38

UNIVERSITY HOSPITAL

7-31-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Harford Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

452 Bourbon St. Harvegrace Md.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

1925
4/8/19359. AGE (in years
last birthday)

32-12

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Dispatcher

10B. KIND OF BUSINESS OR INDUSTRY

Beta Club

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. N. Hughes

14. MOTHER'S MAIDEN NAME

Neva Blair

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

unk.

17. INFORMANT

Patricia D. Hughes 453 Bourbon St. Harvegrace Md.

18. E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Craniocerebral injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Road

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

U.S. Route #40 intersection of st. rt.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 8 67 1:00

21E. INJURY OCCURRED

A WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pulled into path of another car

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

R. S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

July 8, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/11/67

23C. NAME OF CEMETERY OR CREMATORY

Angel Hill Cem.

23D. LOCATION

(City, town, or county)

(State)

Harvegrace Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 11 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Pennington & Son Harvegrace Md.

ADDRESS

Letter from M.E.'s office 7-31-67 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6585		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6585	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNE KATHERINE BERL		2. DATE AND HOUR OF DEATH 7-9-67 3:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21213			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2628 PELHAM AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 11-8-08	9. AGE (In years last birthday) 58	10. AGE (In years last birthday) 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK TYPIST		10B. KIND OF BUSINESS OR INDUSTRY Md. Casualty Co. OFFICE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM BERL		14. MOTHER'S MAIDEN NAME CAROLINE HOLLAND			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Marion Berl, sister, above PATIENT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF LEFT BREAST & EXTENSIVE METASTASIS		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 YEARS	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 8, 1967 to July 9, 1967. that (I) (we) last saw the deceased alive on July 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles S. Harrison				23B. DATE SIGNED 7-9-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. U. OF MD. HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/67		24C. NAME OF CEMETERY OR CREMATORY Fork M. E. Cemetery	
				24D. LOCATION (City, town, or county) (State) Fork, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Tabor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	

0300 AM

0300 PM

WATERGATE

7-1-77

MARYLAND BALTIMORE

BALTIMORE

UNIVERSITY OF MARYLAND

303 BELHAM AVE.

11-8-77

RECEIVED

W

STERN TYPIST OFFICE

WILLIAM BERL

MARYLAND

CAROLINE HOLLAND

PATIENT

VIA

RECEIVED - DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

11

July 1, 1977

Charles E. Harrison

U.S. AIR FORCE HOSPITAL

7-1-77

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6586		67 6586		67 6586	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)			
		WESLIE S. THOMSON			
2. DATE AND HOUR OF DEATH		JULY 8, 1967 7 32 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
UNION MEMORIAL HOSPITAL		MARYLAND			
44		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		3435 GREENMOUNT AVE. 2ND FLOOR			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
M	W	MARRIED SEPARATED	5/26/1898	69 y/o	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
unknown		unknown		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Albert J. Thomson			Eva V. Mitchell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mrs. Iona Stivers, dght, 3231 Lake Ave.	
18. 600.0 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		DEHYDRATION AND MALNUTRITION	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO		ACUTE NECROTIZING CYSTITIS WITH LOCALIZED PERITONITIS	
ANTECEDENT CAUSES		(C) DUE TO		ACUTE PYELONEPHRITIS, BILATERAL	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				M. Newman	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from July 3 1967 to July 8 1967, that (I) last saw the deceased alive on June 8 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
W.H. Oehlert Jr.				July 8, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
WILLIAM H. OEHLERT JR.		THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		7/12/67		Westminster Cemetery Co	
				Westminster, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 11 1967		Robert E. Tarkenton		Schimunek Funeral Home, Inc. 3231 Brehms Lane	

Acute Necrotizing Enteritis with
Localized Peritonitis
Acute Peritonitis, Bile

Yp

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67. 6587 CERTIFICATE OF DEATH					Registered No. 67. 6587					
BIRTH NO.										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <u>HUDSON VIRGINIA US</u>					2. DATE AND HOUR OF DEATH <u>12 M 17 10/62</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residency before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 W 51st</u>					A. STATE <u>MD</u> B. COUNTY <u>Balt Co</u>					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO</u>					
					D. STREET ADDRESS (If rural, give location) <u>77 Dunkirk Rd</u>					
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>		8. DATE OF BIRTH <u>2/17/69</u>		9. AGE (In years last birthday) <u>58</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEPUTY Adm. Asst. to Sec'y of Labor</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO - MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>				
13. FATHER'S NAME <u>John W HUDSON</u>					14. MOTHER'S MAIDEN NAME <u>MABEL WADDELL</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>+</u>					16. SOCIAL SECURITY NO. <u>220-42-8457</u>		17. INFORMANT ADDRESS			
18. <u>465 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (B) <u>PULMONARY EDEMA</u> DUE TO (C) <u>PULMONARY INFARCT</u>					
INTERVAL BETWEEN ONSET AND DEATH										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (A) (this hospital) attended the deceased from <u>7/4/67</u> 19 <u>67</u> to <u>7/8</u> 19 <u>67</u> that (B) (we) last saw the deceased alive on <u>7/7</u> 19 <u>67</u> and that (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>John R Wilke</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED <u>7/8/67</u>		
23C. PHYSICIAN'S NAME (Type) <u>John R WILKE</u> M.D.								23D. ADDRESS <u>MSH</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>July 10, 1967</u>			24C. NAME of CEMETERY or CREMATORY <u>Singleton Chapel</u>			24D. LOCATION (City, town, or county) (State) <u>Gloucester, Virginia</u>	
25A. DATE RECEIVED BY FUNERAL DIRECTOR <u>JUL 11 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			25C. FUNERAL DIRECTOR <u>Wm. C. Brooks</u>			ADDRESS <u>1050 York Rd Towson Md</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6588				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6588			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) BRADLEY LEROY				2. DATE AND HOUR OF DEATH 7-7-67 3-50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland				A. STATE Maryland B. COUNTY A.A.				C. CITY OR TOWN (If outside city limits, write RURAL, and give township) Baltimore - Glen Burnie			
				D. STREET ADDRESS (If rural, give location) 16 Highland Rd. 52-00							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 10-31-13	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HARRY E. BRADLEY				14. MOTHER'S MAIDEN NAME FLORA JUSTICE							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWII				16. SOCIAL SECURITY NO. 204-10-9890		17. INFORMANT Mrs. MARGARET HAVICE		ADDRESS SAME AS #4			
18. 527.1 I				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Car pulmonale							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Emphysema							
				(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-3-1967 to 7-7-1967 , that (I) (we) last saw the deceased alive on 7-7-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Anil M. Joshi				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7-7-67			
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI				23D. ADDRESS Lutheran Hospital of Maryland 730 Abbeville St. Baltimore 21216							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 7-10-67		24C. NAME OF CEMETERY or CREMATORY BIRCH Hill		24D. LOCATION (City, town, or county) (State) BURNHAM Miffling Pa.			
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR Wm. Cook & Brooks Towson, Towson Md.			

Handwritten notes at the top left, including the word "Handwritten" and some illegible scribbles.

Handwritten notes in the upper middle section, including the word "Handwritten" and some illegible scribbles.

Handwritten notes in the lower middle section, including the word "Handwritten" and some illegible scribbles.

Handwritten notes in the lower middle section, including the word "Handwritten" and some illegible scribbles.

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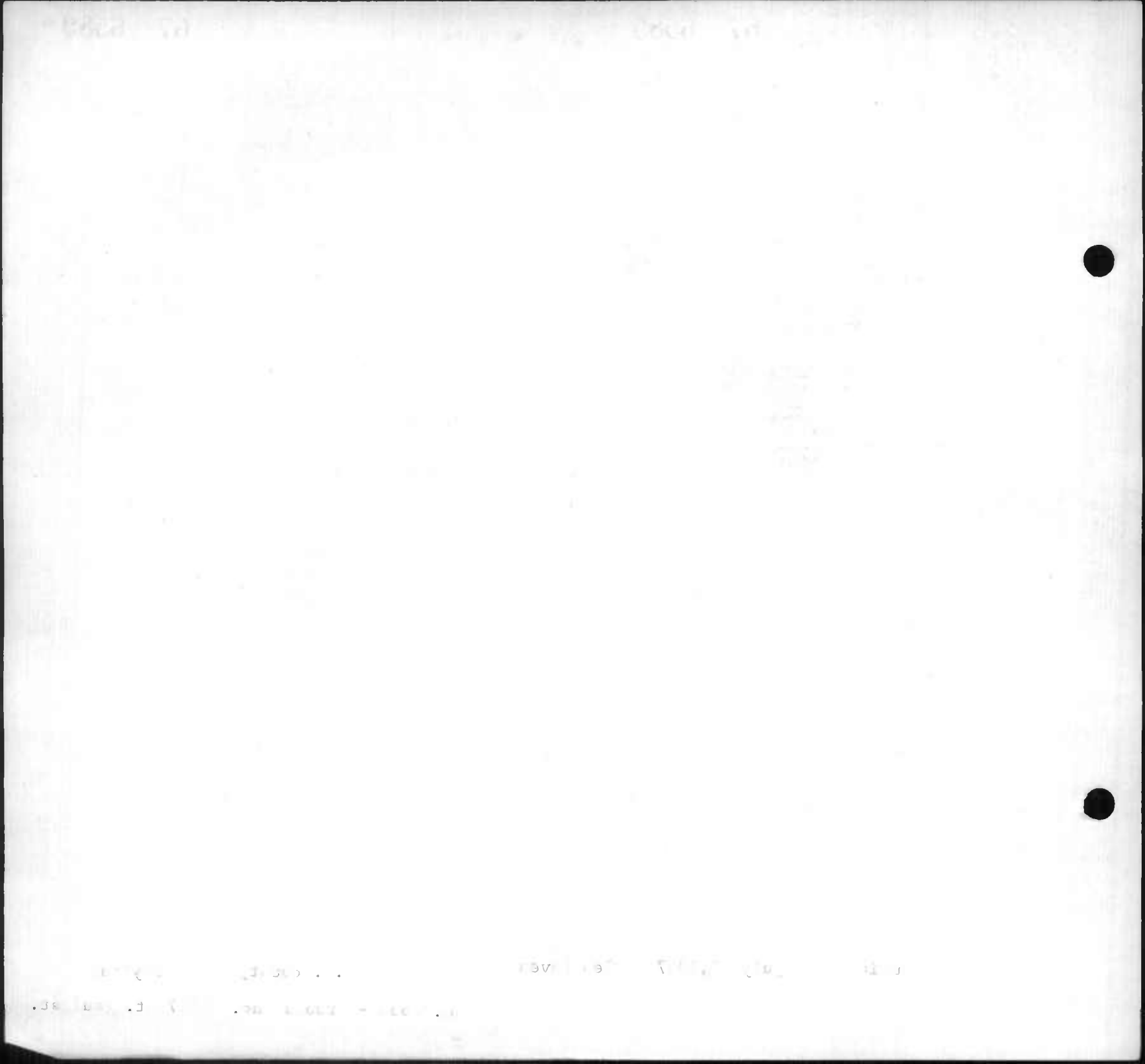
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6589</u>	
BIRTH NO. <u>67-14250 67 6589</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BABY BOY SASSER</u>			
2. DATE AND HOUR OF DEATH <u>JULY 9 1967</u> <u>11:10 A.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>BON SECOURS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Md.</u>			
		D. STREET ADDRESS (If rural, give location) <u>6-03</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>INFANT</u>	8. DATE OF BIRTH <u>JULY 3 1967</u>	9. AGE (In years last birthday) <u>2</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>2</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>UNITED STATES</u>	
13. FATHER'S NAME <u>THURSTON SASSER</u>		14. MOTHER'S MAIDEN NAME <u>LINDA GRIFFIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>762-0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Antecedent causes</u> DUE TO (B) <u>Undetermined</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JULY 8 1967</u> to <u>JULY 9 1967</u> , that (I) (we) last saw the deceased alive on <u>JULY 9 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Estrellita P. Trias M.D.</u>				23B. DATE SIGNED <u>July 9, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>ESTRELLITA P. TRIAS M.D.</u>				23D. ADDRESS <u>BON SECOURS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>July 11, 1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven</u>	
				24D. LOCATION (City, town, or county) (State) <u>A.A. county Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 11 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Sasser</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook - Brooks Inc. 1217 St. Paul st.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6590	
BIRTH NO. 67 6590		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Lawrence Tomlinson</i>		2. DATE AND HOUR OF DEATH <i>July 9 1967 1 10 30 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Franklin Square Hospital</i> 36		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>516 S. Gilmore St</i>			
5. SEX <i>Male</i>	6. RACE <i>wh</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>July 1 1909</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Elevator</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	
13. FATHER'S NAME <i>Mr E Tomlinson</i>		14. MOTHER'S MAIDEN NAME <i>Maud Russell</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no no</i>		16. SOCIAL SECURITY NO. <i>217 03 4083</i>		17. INFORMANT ADDRESS <i>Mrs Viola Tomlinson 516 S Gilmore St</i>	
18. I <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Acute Coronary Insufficiency</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>	
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/9</i> <i>7/9</i> <i>19 67</i> to <i>7/9</i> <i>19 67</i> , that (I) (we) last saw the deceased alive on <i>7/9</i> <i>19 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles A Cahn</i>				23B. DATE SIGNED <i>7/10-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Charles A CAHN</i>		23D. ADDRESS M.D. <i>2145 W Balt St</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-12-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>	
		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 11 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Thomas J. Kerry, Inc 1600 Hollins St</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6591		CERTIFICATE OF DEATH		67 6591	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) SISTER MARY DENISE MATTHEWS R.S.M. DATE AND HOUR OF DEATH JULY 6, 1967 11:30 P.M.					
2. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
37 MERCY HOSPITAL			MARYLAND		
5. SEX F 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH 10-21-1895 9. AGE (In years) 71		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
R. S. M. RELIGIOUS SISTER OF MERCY MARYLAND			MT. ST. AGNES, MT WASHINGTON		
13. FATHER'S NAME HENRY MATTHEWS			14. MOTHER'S MAIDEN NAME TERESA CARROLL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT SISTER CYRIL MT. ST. AGNES CONVENT		
18. 430.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) Cerebrovascular accident		
ANTECEDENT CAUSES			(B) Arteriosclerosis Heart Disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Chronic Bladder infection		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 23, 1967 to JULY 6, 1967 , that (I) (we) lost saw the deceased alive on JULY 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Maria Y. Que				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) MARIA QUE				23D. ADDRESS MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		7/10/67		Mt. St. Agnes	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 11 1967		Robert E. Taylor		H.W. MEARS & SON 805 N. CALVERT ST.	
				24D. LOCATION (City, town, or county) (State)	
				BALTIMORE, MD.	

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67. 6592	
BIRTH NO. 67. 6592		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN E. BRAUN		2. DATE AND HOUR OF DEATH JULY 8, 1967 10:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 29			
D. STREET ADDRESS (If rural, give location) 202 STREMONT ROAD		E. STREET ADDRESS (If rural, give location) 202 STREMONT ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-10-90	9. AGE (In years last birthday) 77	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN A. Braun			
14. MOTHER'S MAIDEN NAME CARRIE BUTCHER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 705-07-6431		17. INFORMANT Mrs. Emma E. Braun, 202 S. Tremont Rd. 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.01		CAUSE OF DEATH Arteriosclerosis Heart disease in failure - Bronchopneumonia			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 8 1967 to JULY 8 1967 , that (I) (we) lost saw the deceased alive on JULY 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. ANGVO		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) G. ANGVO	
23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/11/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	

8288

1981 E. BRADY

JULY 8, 1981

10:15 A

ST. ANNE'S HOSPITAL
WILKINS & CATON AVENUE
BALTIMORE 29, MARYLAND

BALTIMORE
302 TRENTON ROAD
ZONE 29

10:15 A

WHITE MARRIED

4-12-50

73

RETIRED

MARYLAND

U.S.A.

CARDIE

1981 E. BRADY

NO

101-07-6191 ST. ANNE'S HOSPITAL, WILKINS & CATON AVE

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JULY 8

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1981 E

10:15 A

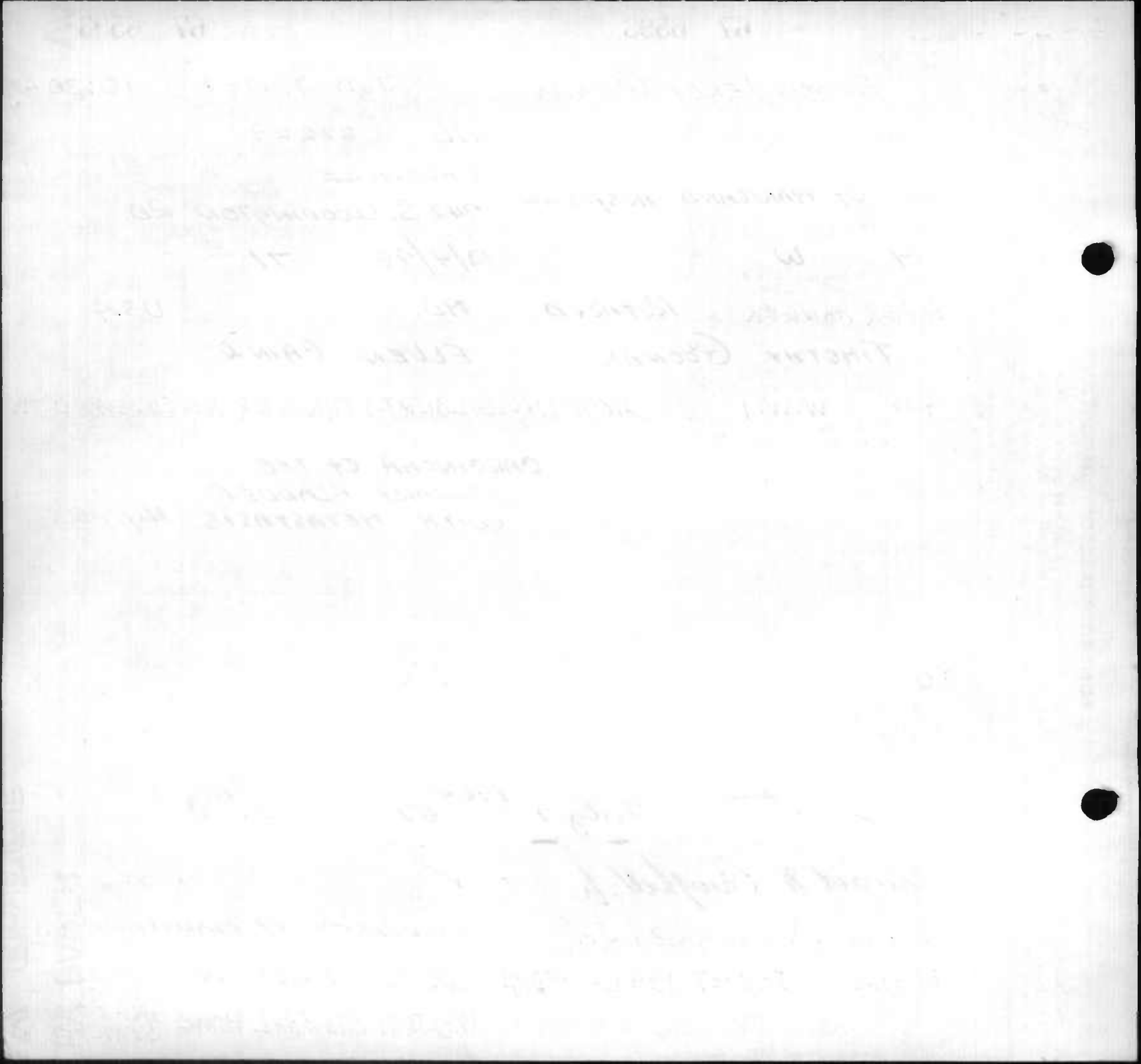
G. KNOX

ST. ANNE'S HOSPITAL, WILKINS & CATON AVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6593 BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6593	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) FRANCIS LEROY GOONAN				JULY 7, 1967 10:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MARYLAND HOSPITAL		A. STATE MD B. COUNTY (21229)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 25-31	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 742 S. WOODINGTON RD.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12/4/96	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAPER HANGER		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME TIMOTHY GOONAN		14. MOTHER'S MAIDEN NAME ELLEN CAIN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I.		16. SOCIAL SECURITY NO. 218-18-3766		17. INFORMANT ADDRESS GILBERT STRICKER 1606 EDGEWOOD RD.	
18. 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CARCINOMA OF THE URINARY BLADDER DUE TO (B) WITH METASTASIS DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1964 to July 7 19 67 , that (I) (we) last saw the deceased alive on July 7 19 67 and that in (my) (four) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Edward W. Campbell, Jr. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 7-7-67	
23C. PHYSICIAN'S NAME (Type) Edward W. Campbell, Jr. M.D.				23D. ADDRESS UNIVERSITY OF MARYLAND HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-10-67		24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMET.	
24D. LOCATION (City, town, or county) (State) BALT. MD 21201					
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS WALTERS FUNERAL HOME PRATT & STRICKER STS.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6594	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 6594 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mrs. MARY B. STEVENS			2. DATE AND HOUR OF DEATH 1-6-67 2 45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Cecil Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Chesapeake D. STREET ADDRESS (If rural, give location) Chesapeake Md 21915		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 8-6-95	9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER		10B. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Brown			14. MOTHER'S MAIDEN NAME Sara Collins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 315-32-1755	17. INFORMANT MARGARET ANN KAUGER		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 15-4X I Uremia		CAUSE OF DEATH Interval 18 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-26-1967 to 7-6-1967, that (I) (we) lost saw the deceased alive on 7-6-230PM 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dong Sup Cha			23B. DATE SIGNED JULY -6-1967		23C. PHYSICIAN'S NAME (Type) DONG SUP CHA
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 7-9-67		
24C. NAME OF CEMETERY or CREMATORY BETHEL CEMETERY			24D. LOCATION (City, town, or county) (State) CHESAPEAKE CITY MD.		
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR PIPPIN FUNERAL HOME	
				ADDRESS ELKTON, MD.	



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. **67-13850**

M.E. CASE NO.

1. NAME OF DECEASED
 (Type or Print)

BABY BOY PURNELL

2. DATE AND HOUR OF DEATH

JULY 4/67 17:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

**BALTIMORE CITY HOSPITALS
 4940 EASTERN AVENUE
 BALTIMORE 21224, MD.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

10-01

D. STREET ADDRESS (If rural, give location)

1021 E. BIDDLE ST.

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

JULY 3/67

9. AGE (In years last birthday)

2/365

If Under 1 Yr. Months: Days: Hours: Min.

1 4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JAMES NELSON

14. MOTHER'S MAIDEN NAME

SUNDAY PURNELL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224 MD.

18. **773.51**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) **HYALINE MEMBRANE DISEASE (RESPIRATORY DISTRESS)**

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

PREMATURITY

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) **(this hospital)** attended the deceased from **JULY 3 19 67** to **JULY 4 19 67**, that (I) (we) last saw the deceased alive on **JULY 4 19 67** and that in (my) **(our)** opinion death occurred on the date and hour and from the causes stated above. (I) **(We)** **(did)** (did not) view the body after death.

23A. SIGNATURE

David Mayman

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

JULY 4/67

23C. PHYSICIAN'S NAME (Type)

DR. DAVID MAYMAN

23D. ADDRESS

M.D.

**BALTIMORE 21224, MD.
 BALTIMORE CITY HOSPITALS 4940 EASTERN AVE.**

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

7-5-67

24C. NAME OF CEMETERY or CREMATORY

Baltimore City Hospitals

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.

JUL 11 1967

25B. NAME OF REGISTRAR

Robert E. Jackson

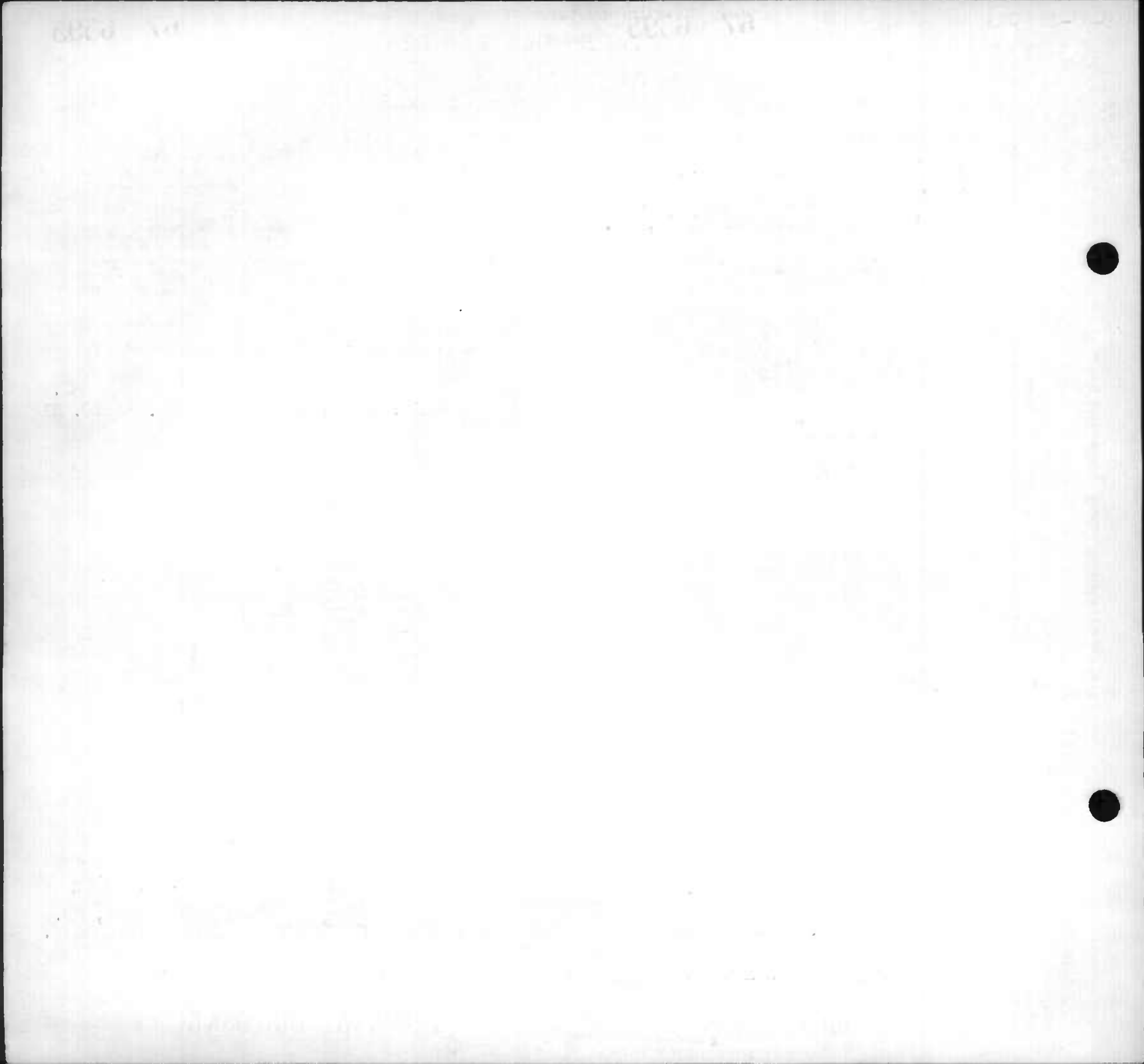
25C. FUNERAL DIRECTOR

HOSPITAL DISPOSAL

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



67. 6596

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6596

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HERMAN SCOTT

2. DATE AND HOUR PRONOUNCED DEAD

July 7, 1967 10:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

131 W. Barre Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

5

8. DATE OF BIRTH

7-14-1910

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ROBBER

10B. KIND OF BUSINESS OR INDUSTRY

ORANGEBURG - S.C.

12. CITIZEN OF
WHAT COUNTRY?
USA.

13. FATHER'S NAME

THOMAS SCOTT

14. MOTHER'S MAIDEN NAME

MARIA BRUNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NY

16. SOCIAL
SECURITY NO.

599-30-8150

17. INFORMANT

ADDRESS

HAROLD PAULIN - PHILA. PA.

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular
DiseaseANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

July 8, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-13-67

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JUL 11 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Marshall Hager 638 N. Gilmor St

ADDRESS

Wm. A. Davis

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6597</u>	
BIRTH NO. <u>67 6597</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOSEPHINE F MACKELL</u>		2. DATE AND HOUR OF DEATH <u>July 8, 1967</u> <u>9:25</u> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>A.A. G</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>HARWOOD</u>			
		D. STREET ADDRESS (If rural, give location) <u>ROUTE 1 BOX 103</u> <u>20776</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>12-9-23</u>	9. AGE (In years lost birthday) <u>43</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Assistance</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co. Stafford</u>		11. BIRTHPLACE (State or foreign country) <u>Harwood, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANKLIN WHITEFIELD</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE SHARPS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-22-2825</u>		17. INFORMANT <u>Beatrice Powell - West River, Md.</u>	
18. <u>593X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <u>Intractable GI hemorrhage</u> (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>36 hr</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>Uremic Colitis</u>		<u>72 hr</u>	
		(C) <u>Hypertension; renal failure</u>		<u>1 month</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 21</u> 19 <u>67</u> to <u>July 8</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 8</u> 19 <u>67</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. V. Russo</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/8/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. V. RUSSO</u>		23D. ADDRESS M.D. <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/12/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Chesw. Memorial</u>	
24D. LOCATION (City, town or county) (State) <u>Queenville, Md.</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>JUL 11 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>	
25C. FUNERAL DIRECTOR <u>William Reese, Jr. - Anna, Md.</u>		25D. ADDRESS			

2
A

1000

1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000

F-400

67. 6598

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67. 6598

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) SILAS ALONZO FAYALL				2. DATE AND HOUR PRONOUNCED DEAD July 9, 1967 10:45 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1713 Cliftview Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 10-13-33	9. AGE (In years last birthday) 34	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIN MILL		10B. KIND OF BUSINESS OR INDUSTRY SPARROWS POINT		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BRUTUS FAYALL				14. MOTHER'S MAIDEN NAME MARY HAMILTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES KOREAN		16. SOCIAL SECURITY NO. 245-186258		17. INFORMANT GERTRUDE FAYALL 2709 E. CHASE ST.			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intracerebral hemorrhage II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Antecedent causes III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 10, 1967							
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 7-15-67		23C. NAME OF CEMETERY or CREMATORY PRIVATE		23D. LOCATION (City, town, or county) (State) ALVIN S.C.	
24A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		24B. NAME OF REGISTRAR Robert E. Fairbank		24C. FUNERAL DIRECTOR JOSEPH KNIGHT FUNERAL HOME		ADDRESS	

10-18-55

The World Tomorrow Ltd

10-18-55

10-18-55

10-18-55

W-420

67 6599

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6599

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES WALLS

2. DATE AND HOUR PRONOUNCED DEAD

July 8, 1967 12:45 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00
702 W. Franklin Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

702 W. Franklin Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

8-10-1937

9. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Laundries

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

James Walls

14. MOTHER'S MAIDEN NAME

Blanch Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Blanch Walls 52 Shaw St

18. 323X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Overdose of narcotics and alcohol
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

July 9, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-13-67

23C. NAME OF CEMETERY or CREMATORY

Brewer Hall

23D. LOCATION

Annapolis Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 11 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

William Reese

ADDRESS

Annapolis Md.



FUNERAL DIRECTOR: IMPORTANT

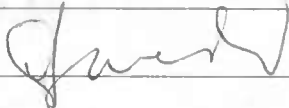
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6600	
67 6600				BIRTH NO.	
M.E. CASE NO.				67 6600	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MARY S. DAVIS			July 3, 1967		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
39 Provident Hospital 1514 Division Street			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			2456 Druid Hill Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	Negro	Married	Nov. 12, 1891	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Mecklingberg Co., Va.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James Pulliam			Lula Harris		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			212-28-2346		Fred Davis, 2456 Druid Hill Avenue
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Cerebrovascular Accident		
ANTECEDENT CAUSES			DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Spontaneous Hypertension		
			(C) Acute Heart Failure		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 1950</u> to <u>July 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Samuel H. Coffey</i>				July 67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Samuel H. Coffey				4015 Park Heights Rd	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		July 10, 1967		Baltimore National	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 11 1967		Robert E. Farber		Edgar L. Lynch 2463 Druid Hill Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6601	
BIRTH NO. 67 6601		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Vernon Tasker		2. DATE AND HOUR OF DEATH July 6, 1967 1:20p M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 17-02 D. STREET ADDRESS (If rural, give location) 1217 Etting Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) ?	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ?	
12. CITIZEN OF WHAT COUNTRY? ?		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Vera Lee-daughter 2133 McCulloh Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 331X I		CAUSE OF DEATH (A) DUE TO Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 6, 1967 to July 6, 1967 , that (I) (we) lost saw the deceased alive on July 6, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  C. Laredo				23B. DATE SIGNED July 7, 1967	
23C. PHYSICIAN'S NAME (Type) C. Laredo		23D. ADDRESS M.D. 1514 Division Street-Baltimore, Maryland(17)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave			

JUL 11 1967

Robert E. Laredo

6611

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 6602		67 6602	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Spencer, William			7-5-67 7:10P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
39 Provident Hospital, Inc. Baltimore, Maryland 21217			Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1347 N. Stockton Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Negro	Divorced	12-6-19	43 47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Unemployed		None	Virginia		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
?			Arkana Spencer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Emma Scott (Niece) 2508 Terra Firma Rd.	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) CIRRHOSIS of the LIVER (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-27-67 19 to 7-5-67 19, that (I) (we) last saw the deceased alive on 7-5-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Gregorio S. Tengco M.D.				7-5-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
GREGORIO S. TENGCO M.D.				1514 Division Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/11/67		Mt Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
		Adolphus Halstead		1206 W North Ave	
JUL 11 1967 6602, 6602, 6602					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6603	
BIRTH NO. 67 6603		CERTIFICATE OF DEATH			
M.E. CASE NO. 7-5141					
1. NAME OF DECEASED (Type or Print) TEMPLETON, MILDRED		2. DATE AND HOUR OF DEATH 7/10/67 12:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSP		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-36 D. STREET ADDRESS (If rural, give location) 1103 DEMARCAY WAY			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-21-05	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME FREDERICK VOGT		14. MOTHER'S MAIDEN NAME ANNA CASNER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-5602		17. INFORMANT James Templeton 1103 Demarcay Way	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO CEREBRAL VASC. ACCIDENT (B) DUE TO HYPERTENSION (C) DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 6 HRS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/9 19 67 to 7/10 19 67 , that (I) (we) last saw the deceased alive on 7/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry K. Genant		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/10/67	
23C. PHYSICIAN'S NAME (Typo) Harry K. Genant		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/67		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967			
25B. NAME OF REGISTRAR John A. Morgan, Inc.		25C. FUNERAL DIRECTOR 3000 E. Balto. St.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6604		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6604	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LEONARD DOYLE			2. DATE AND HOUR OF DEATH JULY 8, 1967		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1615 W. Lexington St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 19-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 1615 W. Lexington St.		
5. SEX Male	6. RACE Col.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 8, 1891	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer retired		10B. KIND OF BUSINESS OR INDUSTRY G & E Co.		11. BIRTHPLACE (State or foreign country) Barbadoes B.W.I	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-05-6125		17. INFORMANT ADDRESS Eliza Doyle 1615 W. Lexington St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I			CAUSE OF DEATH (A) CARCINOMA OF SIGMOID COLON (B) DIVERTICULITIS OF COLON (C) SECONDARY ANEMIA INTERVAL BETWEEN ONSET AND DEATH 3 mos.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 4/4/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MASS IN COLON (SIGMOID)		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/11/67 19 to 7/8/67 19, that (I) (we) last saw the deceased alive on 7/8/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. C. WELCOME				23B. DATE SIGNED 7/10/67	
23C. PHYSICIAN'S NAME (Type) H. C. WELCOME		23D. ADDRESS 1106 Harlem Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/1967		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Ceder Hill Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Williams Funeral Home 319 N. Schroeder St.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67. 6605		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67. 6605	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Flora A. Ait		2. DATE AND HOUR OF DEATH July 9 1967 16 30 A	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 28-07		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
6. STREET ADDRESS (If rural, give location) 4408 Old Frederick Rd.		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 11/17/04	
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph E. Vaughn		14. MOTHER'S MAIDEN NAME Margaret	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Charles Mr. Joseph Ait, Jr. ADDRESS 4408 Old Frederick Rd. - 21229	
18. 154X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Carcinoma of rectosigmoid colon with perforation and peritonitis		1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pneumonia, right upper lobe		3 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 5 1967 to July 9 1967 , that (I) (we) last saw the deceased alive on July 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nam Do H Yang		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 9, 1967	
23C. PHYSICIAN'S NAME (Type) NAM DOH YANG		M.D. 23D. ADDRESS Bon Secours Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/67		24C. NAME OF CEMETERY or CREMATORY Western Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Witzke F. D.	
25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		ADDRESS			

7/12/67 - Correction form from funeral director.

Jfc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67. 6606	
BIRTH NO. 67. 6606				M. 67. 6606	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH 07/07/67 6:50P	
1. NAME OF DECEASED (Type or Print) KAHLER E. GRACE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE 21229, MD				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) SHANGRI LA NURSING HOME HARLEM LANE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 08/2/1880	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM HENRY LOTZ			14. MOTHER'S MAIDEN NAME LAURA VIRGINIA LANGE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. UNKNOWN		
17. INFORMANT Dr. Paul Lange Lotz-Box 327-Plainfield, N. J.			18. HOSPITAL RECORD ST AGNES HOSPITAL		
18. CAUSE OF DEATH 4-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE ACUTE MYOCARDIAL INFARCTION ABOUT 10 DAYS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-2-1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory Lap.		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 07/01 19 67 to 07/07 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 07/07 19 67 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE C. Matthey M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) C. MATTHEY		23D. ADDRESS M.D. WILKENS & CATON AVES ST. AGNES HOSPITAL-BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/10/67	24C. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		24D. LOCATION (City, town, or county) (State) Randallstown, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Witzke F. D. - 4101 Edmonds n Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6607	
BIRTH NO. 67-13439 67 6607		CERTIFICATE OF DEATH		7/9/67 9:20 PM	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY GIRL GREEN		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 WILKENS AND CATON AVE BALTIMORE, MD.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1024 CHARING MARTIN CT.		M.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH 7/9/67	9. AGE (In years last birthday) NB	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 10 5
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) US, BALTO., MD.	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME CALVIN EDWARD GREEN		14. MOTHER'S MAIDEN NAME NANCY MARIE REITZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ST. AGNES HOSP. RECORDS WILKENS & CATON	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Prematurity (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JULY 9, 1967 to JULY 9, 1967, that (X) (we) lost saw the deceased alive on JULY 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Esther Edery		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/10/67	
23C. PHYSICIAN'S NAME (Type) ESTHER EDERY		23D. ADDRESS M.D. ST. AGNES HOSPITAL WILKENS AND CATON			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/67		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967			
25B. NAME OF REGISTRAR C. E. Edery		25C. FUNERAL DIRECTOR Witzke F. D.		ADDRESS - 4101 Edmondson Ave.	

ON THE TITLE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67. 6608		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67. 6608	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) DAVIDSON SYLVIA I			2. DATE AND HOUR OF DEATH JULY 7 1967 4:00 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2211 WILKENS AVE.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-14-89	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE - WIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? AMERICA
13. FATHER'S NAME UNKNOWN CHARLES C. KLAPP			14. MOTHER'S MAIDEN NAME UNKNOWN ANNA-MARY-JORDEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ✓		16. SOCIAL SECURITY NO. 218 09 8794	17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Acute myocardial infarction (B) DUE TO Cardiac failure (C) DUE TO Pulmonary embolism R.I.		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 3 19 67 to JULY 7 19 67 , that (I) (we) lost saw the deceased alive on JULY 7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. George Angov			23B. DATE SIGNED 07-07-67		23C. PHYSICIAN'S NAME (Type) DR. GEORGE ANGOV
23D. ADDRESS CATON & WILKENS AVE. BALTIMORE MD			23E. MED. DIRECTOR Stoff Phys. X		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/10/67		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK	
24D. LOCATION (City, town, or county) (State) Baltimore Md		24E. NAME OF REGISTRAR Robert E. Adams		24F. FUNERAL DIRECTOR 885 W. Market - 1300 Eutan Place	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

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4:00 P

JULY 3 1967

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DAVIDSON

IN

847 HOURS

ST. AGNES HOSPITAL

2111 WILKINS AVE.

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FEMALE WHITE

AMERICA

7-1-67

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2111 WILKINS AVE. BALTIMORE MD

AMERICA

67. 6609

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67. 6609

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN HENRY WOODLAND

2. DATE AND HOUR PRONOUNCED DEAD

June 27, 1967 3:35 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2103 W. North Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

4-2-1899

9. AGE (In years
last birthday)

68?

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Woodland

14. MOTHER'S MAIDEN NAME

Lenge Woodland-1913

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 443X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Hypertensive Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-3-67

23C. NAME OF CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

Baltimore

June 28, 1967

(City, town, or county)

(State)

2nd

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 11 1967

VS 151-REV. 1/1

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. Some words like "Lecture" and "The" are faintly visible.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
67. 6610		CERTIFICATE OF DEATH	
BIRTH NO.		Registered No. 105-94-16	
M.E. CASE NO. <u>67. 6610</u>		2. DATE AND HOUR OF DEATH <u>7/8/67 12:30 AM</u>	
1. NAME OF DECEASED (Type or Print) <u>Lowery, Junius</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Johns Hopkins Hospital</u>		A. STATE <u>MARYLAND</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
<u>33</u>		D. STREET ADDRESS (If rural, give location) <u>1707 WEST LEXINGTON STREET</u>	
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>9-15-02</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <u>62</u> <u>64</u>
13. FATHER'S NAME <u>JUNIUS Lowery</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ada Rhodes</u>		ADDRESS <u>Same</u>	
18. <u>331X1</u>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <u>CEREBROVASCULAR ACCIDENT</u>	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO	
ANTECEDENT CAUSES		(B) _____	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO	
(C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>28 days</u>	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 10</u> 19 <u>67</u> to <u>July 8</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 8</u> 19 <u>67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>John T. Flaherty</u>		23B. DATE SIGNED <u>7/8/1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN J. FLAHERTY</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-11-67</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Interoceanic Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Severna Park Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 11 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Clay Robinson</u>		ADDRESS <u>100 Cranberry Dr</u>	

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9-205

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6611		CERTIFICATE OF DEATH		67 6611	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Perris Mrs Irene		7/3/67 at 10:45 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Church Home & Hospital		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		209 N. Dallas Ct.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. If Under 24 Hrs. Months: Days Hours: Min.
7	N	Married	6-15-97	65 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Employed		Unknown		Unknown	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Samuel Richardson		Fanny Wallace		American	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Eddie Purvis	
				ADDRESS	
				Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I 153.81		Colon carcinoma metastatic to bladder.			
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
4/14/67		Carcinoma Colon metastatic to bladder			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 3, 1967 to July 3, 1967, that (I) (we) last saw the deceased alive on July 3, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Asst. Dir.				7-3-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. M. J. Tan		CH & H.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-6-67		MT. Auburn Cem.	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 11 1967		Robert E. Fairbank		Cherry O. Wilson	
				ADDRESS	
				100 Brimley Ave.	

BY BILL

BY BILL

April 10, 1942

April 10, 1942

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6612	
BIRTH NO. 67 6612		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN WILLIE BRIGHT			
2. DATE AND HOUR OF DEATH JULY 9, 1967 1 15 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		A. STATE MARYLAND B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5-02			
		D. STREET ADDRESS (If rural, give location) 1035 ORLEANS ST. 21202			
5. SEX m	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/10/18	9. AGE (in years last birthday) 48	10. If Under 1 Yr. Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROUNDSKEEPER		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) S. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Melvin Davis			14. MOTHER'S MAIDEN NAME Sammie Bright		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 246-16-5436	17. INFORMANT Berne C. Bright		ADDRESS Lanier
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ASPIRATION (SUFFOCATION) DUE TO (B) UREMIA DUE TO (C) CHRONIC GLOMERULONEPHRITIS 2 yrs - 3 mo		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 3 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from APRIL 19 1965 to JULY 9 19 1967 , that (I) was last saw the deceased alive on JULY 9 19 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did did not view the body after death.					
23A. SIGNATURE Gary N. Wilner M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/9/67	
23C. PHYSICIAN'S NAME (Type) GARY N. WILNER MD.		23D. ADDRESS University of Md. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-67		24C. NAME of CEMETERY or CREMATORY New Hill Cent	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Dietrich Funeral Home	
				ADDRESS Baltimore, Md.	

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67 6613

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6613

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ELIJAH GREEN

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1967

9:05 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

53-00

D. STREET ADDRESS (If rural, give location)

176 Winters Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

May 21, 1908

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Orangeburg, S. Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Elijah Green

14. MOTHER'S MAIDEN NAME

Ida McPhearson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebrocranial injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

6-28-67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Head injury

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Apartment house

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Lockwood Apts.

1370 E. Belvedere Avenue

21D. TIME
OF INJURY
(APPROX.)

6-28-67

(Month) (Day) (Year) (Hour)

4:00 P.

21E. INJURY OCCURRED

WHILE AT
WORK

X

NOT WHILE
AT WORK

□

21F. HOW DID INJURY OCCUR?

Fell from ladder while working

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-7-67

23C. NAME OF CEMETERY or CREMATORY

Northern Star Cem.

23D. LOCATION

(City, town, or county)

(State)

Rocky Mount N.C.

24A. DATE REC'D BY HEALTH DEPT.

JUL 11 1967

24B. NAME OF REGISTRAR

Robert E. Fairburn

24C. FUNERAL DIRECTOR

Stokes Funeral Home

ADDRESS

Rocky Mount

May 24 1907

George Washington

John McPherson

John

John McPherson

George Washington

John

John

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George Washington

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John

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
67. 6614 CERTIFICATE OF DEATH					Registered No. 67. 6614						
BIRTH NO.					M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) <u>Venus Lee</u>					2. DATE AND HOUR OF DEATH <u>6/28/67 8:30 p.m.</u>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>435 W. Balto. Dem.</u>					A. STATE <u>Maryland</u>						
					B. COUNTY						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>						
					D. STREET ADDRESS (If rural, give location) <u>121 Bennett St</u>						
5. SEX <u>Female</u>		6. RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>4-6-92</u>		9. AGE (In years last birthday) <u>75</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
13. FATHER'S NAME <u>Stearns Montgomery</u>					14. MOTHER'S MAIDEN NAME <u>Rebecca Bradley</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Rudolph Lee</u>		ADDRESS <u>Same</u>		
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarct</u>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <u>ASCVD</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> (Post mortem)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Complete occlusion of Lt Femoral A, 2 days previous</u>											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>David J. Steinbauer</u>								23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
<u>Burial</u>		<u>7-3-67</u>		<u>Mt Calvary Cmt</u>		<u>Brooklyn</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
<u>JUL 11 1967</u>		<u>Robert E. Farkner</u>		<u>Clay G. Wilson</u>		<u>1001 Brantley Ave</u>					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67. 6615					67. 6615					
BIRTH NO.					Registered No.					
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) LAVINIA HILL					
2. DATE AND HOUR OF DEATH 6/29/67 2 50 P.M.										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
(If not in hospital or institution, give street address or location)					D. STREET ADDRESS (If rural, give location) 2836 WESTWOOD AVE.					
5. SEX FEMALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-18-01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Walter Tydings					14. MOTHER'S MAIDEN NAME Sophie Lowery					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-24-8220		17. INFORMANT Claude Hill		ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) DIABETIC KETOACIDOSIS WITH COMA					INTERVAL BETWEEN ONSET AND DEATH 3 DAYS					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIAL OCCLUSION LEFT ILIAC ARTERY										
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6/29 19 67 to 6/29 19 67 , that (I) (we) last saw the deceased alive on 6/29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Oscar E. Fernandini M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/29/67		
23C. PHYSICIAN'S NAME (Type) OSCAR E. FERNANDINI M.D.					23D. ADDRESS Lutheran Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-67		24C. NAME OF CEMETERY OR CREMATORY MT. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967			25B. NAME OF REGISTRAR R. E. E. E.			25C. FUNERAL DIRECTOR Cherry O Wilson			ADDRESS 204 Oakley St	

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Hill

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Hill

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 6616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6616

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Bill WILLARD		2. DATE AND HOUR PRONOUNCED DEAD 7-6-67 12:14 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF DECEASED IF NOT IN HOSPITAL OR INSTITUTION, OR STREET ADDRESS OR LOCATION 948 W. Lexington Street - Amb. Crew #1		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-01 D. STREET ADDRESS (If rural, give location) 948 W. Lexington Street	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 2, 1913
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10B. KIND OF BUSINESS OR INDUSTRY State	9. AGE (In years last birthday) 54
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 237-26-7543	17. INFORMANT Nannie Jones
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) CHARLES S. SPRINGATE, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 7-10-67	23C. NAME OF CEMETERY or CREMATORY Pleasant Grove	23D. LOCATION (City, town, or county) (State) Wendell N. Carolina
24A. DATE REC'D BY HEALTH DEPT. JUL 11 1967	24B. NAME OF REGISTRAR Robert E. Fairbanks	24C. FUNERAL DIRECTOR William Toney Spring Hope, N.C.	ADDRESS

Marriage Record and Social Security Card of
Deceased plus Widow's Affidavit 7-17-67 M.H.

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 6617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6617

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) AGNES MAKEN		2. DATE AND HOUR PRONOUNCED DEAD July 6, 1967 8:45 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1635 Division Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1635 Division Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 34
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) S. Carolina
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION	18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Right bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fatty metamorphosis of liver		
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
	19A. DATE OF OPERATION 7-11-67	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
	22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
	ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>
	EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7-11-67	23C. NAME OF CEMETERY or CREMATORY Greenville Cem.
24A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		24B. NAME OF REGISTRAR Robert E. Farkas	24C. FUNERAL DIRECTOR ATkins - Arnold - Sheppard Funeral Home
		24D. LOCATION (City, town, or county) (State) Greenville S.C.	ADDRESS Greenville, S.C.

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6618				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6618	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ROBINSON, GENEVA ODESSA				2. DATE AND HOUR OF DEATH 7/9/1967 5:35 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 416 N. CHAPEL STREET 21231			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-6-24	9. AGE (In years last birthday) 43	If Under 1 Yr. Months Days Hours		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge Md		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM BANK				14. MOTHER'S/MAIDEN NAME GLADYS TURNER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Wilhelmina Robinson Lane	
18. 5-8-1-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLUS				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ALCOHOLIC CIRROSIS. ACTIVE (C) ASCITES - 2° to 3°			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (W) (this hospital) attended the deceased from July 3, 1967 to July 9, 1967 , that (A) (we) last saw the deceased alive on July 9, 1967 and that in (W) (our) opinion death occurred on the date and hour and from the causes stated above. (W) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John T. Flaherty				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/9/67	
23C. PHYSICIAN'S NAME (Type) JOHN T. FLAHERTY				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-67		24C. NAME OF CEMETERY OR CREMATORY Balto Nat Cent		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR John T. Flaherty		25C. FUNERAL DIRECTOR Edgar Wilson		ADDRESS 1000 Broadway W	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67. 6619	
BIRTH NO. 67. 6619		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA M. OTEY		2. DATE AND HOUR OF DEATH 7/8/67 1:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		D. STREET ADDRESS (If rural, give location) 1701 MADISON AVE		17-02	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 8-4-15	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) ALA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BENJAMIN KIDD		14. MOTHER'S MAIDEN NAME DELLA TYSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 236-34-8675		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Metastatic CA breast (B) DUE TO c pericardial tamponade (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Poss myeloma; CA cervix					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7/5/67 to 7/8/67, that (I) (we) last saw the deceased alive on 7/8/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Peter J. Rosen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/8/67	
23C. PHYSICIAN'S NAME (Type) PETER ROSEN		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-67		24C. NAME OF CEMETERY or CREMATORY Crown Cent	
24D. LOCATION (City, town, or county) Towson Md		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Thoyl Wilson		25D. ADDRESS 1000 Crumby Ln			

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Metabolic CA breast
to pericardial tamponade

For myeloma CA virus

Peter J Green

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6620	
BIRTH NO. 67 6620		CERTIFICATE OF DEATH		Registered No. 67 6620	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LARRY J. DAVIS (Lindsey)		2. DATE AND HOUR OF DEATH 7/9/67 12:30 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hosp. 38		STATE Md. B. COUNTY Balt.			
5. SEX M		6. RACE N		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		8. DATE OF BIRTH 2/3/48	
13. FATHER'S NAME William DAVIS		14. MOTHER'S MAIDEN NAME ROSA LINDSAY TERRELL		9. AGE (In years last birthday) 19	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Md	
17. INFORMANT MOTHER		ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Hepatic Failure		INTERVAL BETWEEN ONSET AND DEATH 7 Days	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) Hepatitis		3 WEEKS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hemoglobin S-S		LIFE	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/28 19 67 to 7/9 19 67, that (I) (we) last saw the deceased alive on 7/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David A. Shafritz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/9/67	
23C. PHYSICIAN'S NAME (Type) David A. Shafritz		23D. ADDRESS University of Maryland Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem	
24D. LOCATION (City, town, or county) Brooklyn		(State) Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR George W. Wilson, 1400 Blandford Ave	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6621	
BIRTH NO. 67 6621				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ellia M. Pope</i>			
2. DATE AND HOUR OF DEATH		<i>June 28 1967</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE WHERE DECEASED LIVED. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		<i>Maryland</i>		<i>15-47</i>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)		<i>2223 Braddish Ave.</i>	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Female</i>	<i>C</i>	<i>Widow</i>	<i>March 31 1888</i>	<i>79</i>	<i>Housewife</i>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
<i>Wakefield Va</i>		<i>USA</i>		<i>Addison D. Owens</i>	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>Patsy Lanley</i>		<i>No</i>		<i>No</i>	
17. INFORMANT		ADDRESS			
<i>Dr Addison Pope</i>		<i>4622 Maple Ave</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) <i>Arteriosclerotic Heart Disease</i>			
ANTECEDENT CAUSES		(B) <i>with Angina & congestive heart failure</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>many yrs.</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<input type="checkbox"/>				<input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/6 1967</i> to <i>6/28 1967</i> that (I) (we) last saw the deceased alive on <i>6/6 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Eljah Saunders</i> M.D.				23B. DATE SIGNED <i>6/30/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>ELIJAH SAUNDERS</i> M.D.				23D. ADDRESS <i>3414 Duwall Ave.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>7-3-67</i>		<i>Mt Calvary Cent</i>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 11 1967</i>			
<i>Brooklyn Md</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>			
25C. FUNERAL DIRECTOR ADDRESS <i>Eljah Saunders 1000 Brantley Ave</i>					

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6622

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM B. WEST

2. DATE AND HOUR PRONOUNCED DEAD

July 7, 1967 7:17 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CLIFTON PARK

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

318 Suter Road Kingsville, Maryland

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Sept. 9, 1931

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Alfred West

14. MOTHER'S MAIDEN NAME

Ethel Crawley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

214-30-4794

17. INFORMANT

Alfred West 318 Suter Rd.

ADDRESS

18.

E981X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO Massive bilateral hemothorax

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) DUE TO Bilateral Bullet hole in lung
parenchyma

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

21

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unknown

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

7 7 67

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject shot

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/12/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

Baltimore

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 11 1967



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6623

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **WILLIAM WOODLEY** 2. DATE AND HOUR PRONOUNCED DEAD **July 5, 1967 1:30 a.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **46 Lutheran Hospital** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) **A. STATE Maryland B. COUNTY**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **46 Lutheran Hospital** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **3231 Yosemite Avenue**

5. SEX **Male** 6. RACE **Colored** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Single** 8. DATE OF BIRTH **Dec. 10, 1949** 9. AGE (in years last birthday) **17**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Baltimore Maryland** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **William Woodley** 14. MOTHER'S MAIDEN NAME **Erma L. King**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. **216-54-5291** 17. INFORMANT **Erma L. Hayes** ADDRESS **3231 Yosemite Ave.**

18. CAUSE OF DEATH **Craniocerebral injuries** INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **YES** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **YES**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Street** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **Forrest Park Ave. NEAR Dennison St.**

21D. TIME OF INJURY (APPROX.) **7 4 67 11:05** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **Fell from car**

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **R. S. Fisher** CHIEF MEDICAL EXAMINER ☒ DATE SIGNED **July 5, 1967**

EXAMINER'S NAME (Type) **Russell S. Fisher, M.D.** M.D. ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **7/10/67** 23C. NAME OF CEMETERY or CREMATORY **Baltimore National Cemetery** 23D. LOCATION (City, town, or county) (State) **Baltimore Md.**

24A. DATE REC'D BY HEALTH DEPT. **JUL 11 1967** 24B. NAME OF REGISTRAR **Robert E. Jackson** 24C. FUNERAL DIRECTOR **William Phillips** ADDRESS **1727 N. Mount St.**

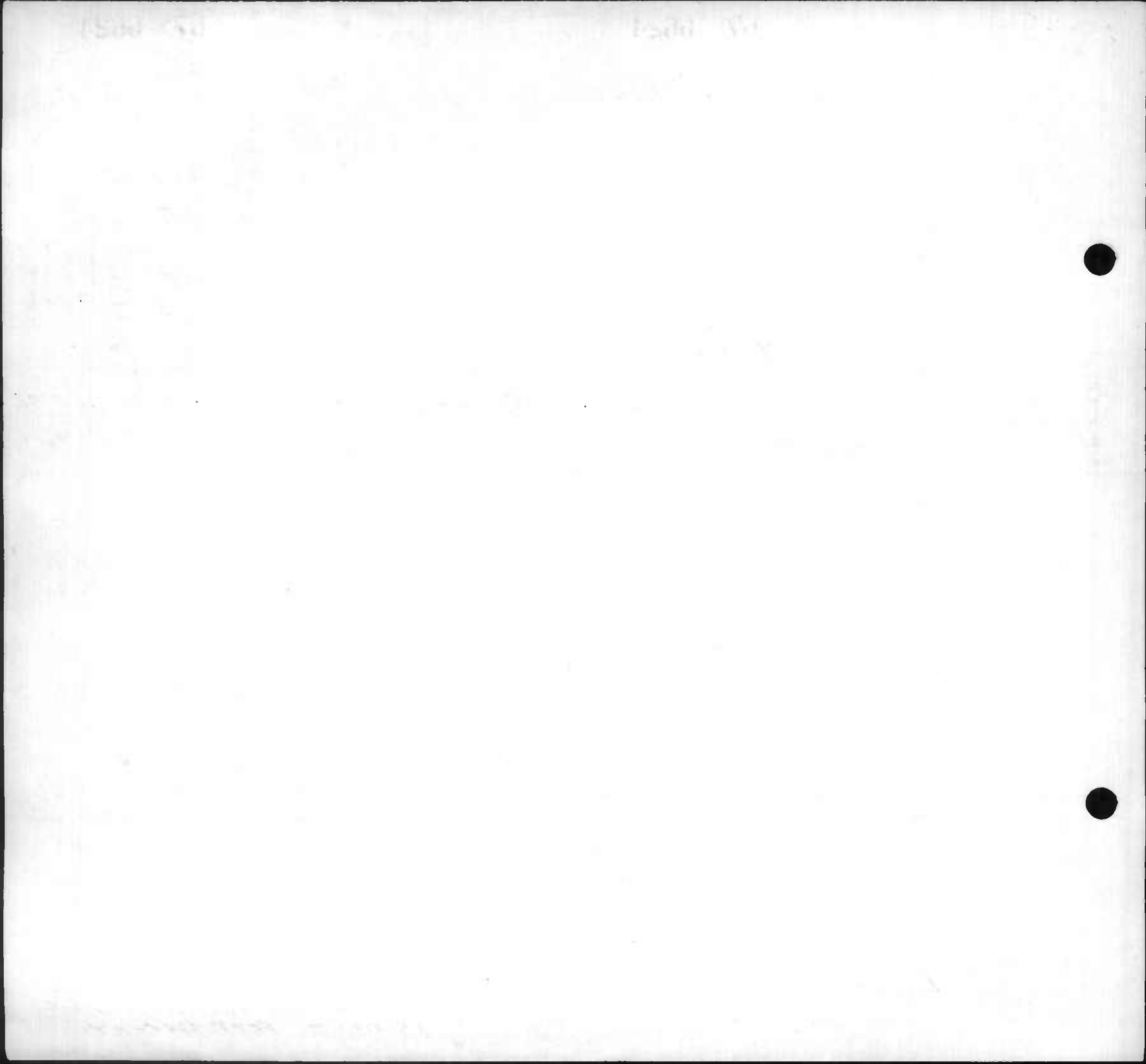
VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6624	
BIRTH NO. 67 6624				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH 7-8-67 19:30 A.M.	
1. NAME OF DECEASED (Type or Print) John Williams.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General Hosp.				A. STATE Maryland.	
				B. COUNTY 24-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21230	
				D. STREET ADDRESS (If rural, give location) 1634 E. CLEMENT St.	
5. SEX M.	6. RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11-23-89	9. AGE (In years last birthday) 77.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman			11. BIRTHPLACE (State or foreign country) SWEDEN.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I			16. SOCIAL SECURITY NO. 215-09-3389	17. INFORMANT ADDRESS Constance Williams 1634 E. Clement St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver			CAUSE OF DEATH (A) DUE TO nutritional		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CNF					
19A. DATE OF OPERATION July 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED C - I bleeding		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that this (this hospital) attended the deceased from 6-25 19 67 to 7-8 19 67 , that we (we) last saw the deceased alive on 7-8 19 67 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard N. Reed M.D.				23B. DATE SIGNED 7-10-67.	
23C. PHYSICIAN'S NAME (Type) Richard N. REED M.D.				23D. ADDRESS 1213 Light Street.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/67		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery Baltimore, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles L. Stevens Funeral Home, Inc. 6150 E. FORT MYNANT			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

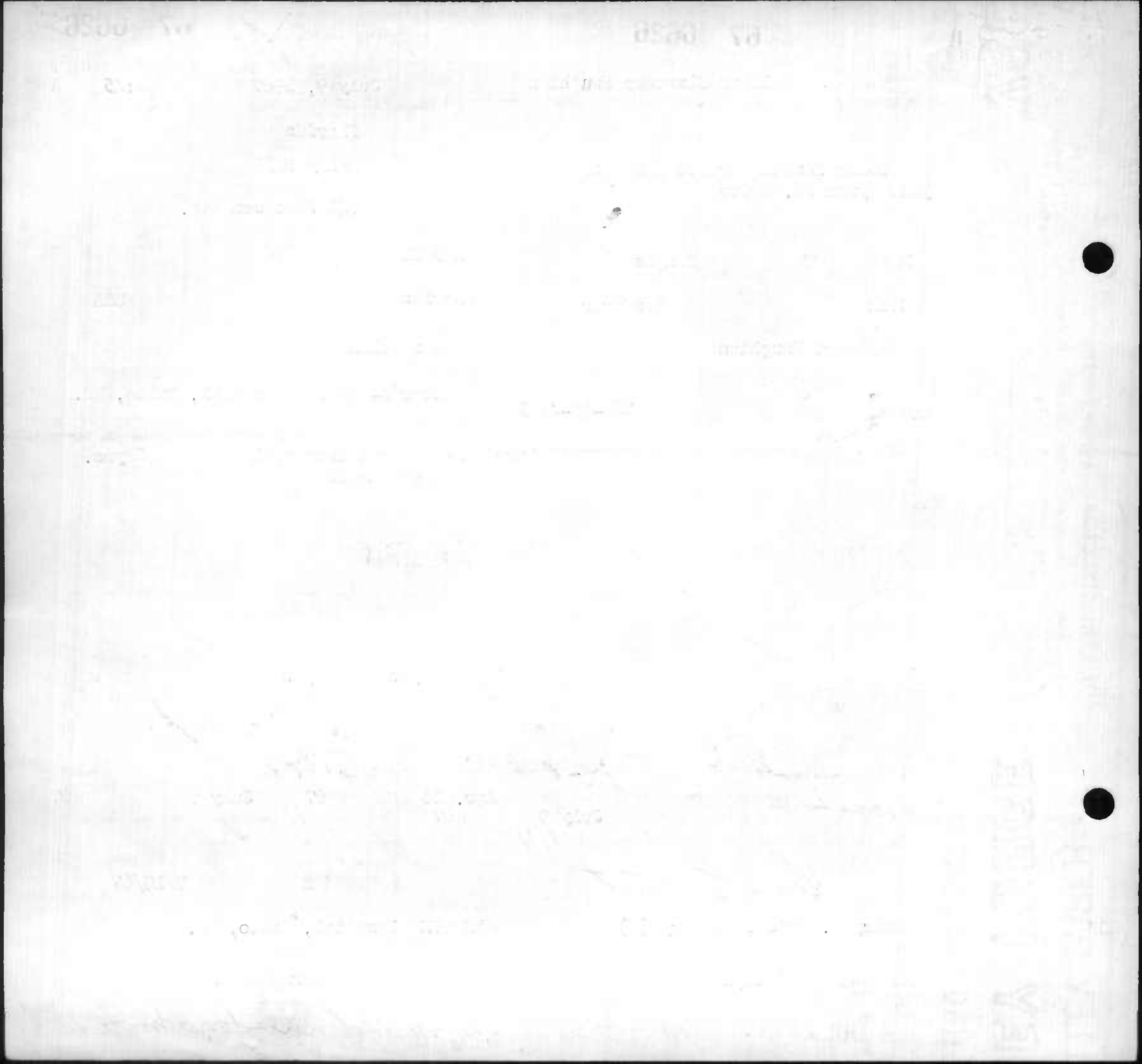
BIRTH NO. 67 6625		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6625	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Allan Sinclair Blackford		2. DATE AND HOUR OF DEATH 7-10-1967 4 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 5701 Leithwalk Road		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 5701 Leithwalk Road	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-26-1897	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Expeditor Ret'd.		10B. KIND OF BUSINESS OR INDUSTRY Bethlem Steel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Blackford		14. MOTHER'S MAIDEN NAME Mary Thomas	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 227-09-5651		17. INFORMANT Mrs. Grace Blackford	
				ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 1810 I Disease or condition directly leading to death Antecedent causes Diseases or conditions, if any, giving rise to the above cause (A) stating the underlying condition last. II Other significant conditions contributing to the death but not related to the disease or condition causing it. None		CAUSE OF DEATH (A) DUE TO Carcinoma of Bladder & Metastasis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 7 years	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 4-26-1961 to 7-10-1967, that (I) (we) last saw the deceased alive on 7-10-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Leon Ashman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-10-67	
23C. PHYSICIAN'S NAME (Type) Dr. Leon Ashman		23D. ADDRESS M.D. 5907 Gwyn Oak Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-12-1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Farkema	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road		25D. BALTO., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 6626					Registered No. 67 6626					
CERTIFICATE OF DEATH										
BIRTH NO. 67 6626					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) William Clarence Haughton					2. DATE AND HOUR OF DEATH July 9, 1967 1:45 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Pk. Drive					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Florida B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Holly Hill D. STREET ADDRESS (If rural, give location) 542 Jacobson Ave.					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 1/5/11	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Florida			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Albert Haughton					14. MOTHER'S MAIDEN NAME Eva Wells					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 261-05-4983		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Carcinoma of left lung with metastases (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
19A. DATE OF OPERATION 2/16/68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Apr. 26 1967 to July 9 1967 , that (I) (we) last saw the deceased alive on July 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Henry S. Crist M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 7/10/67		
23C. PHYSICIAN'S NAME (Type) Henry S. Crist, SA Surg (R)					23D. ADDRESS US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Removal			24B. DATE 7/11/1967		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State) Daytona Beach, Florida		
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967			25B. NAME OF REGISTRAR Robert E. Fairley, M.D.			25C. FUNERAL DIRECTOR Wm. J. Finkbeiner, Balto, Md.			ADDRESS	



01 0057

Edward Tetter

RECEIVED

BREITENBURG

RECEIVED GENERAL HOSPITAL

4405 Belwood Ave

11/30/50 #7

Male White Widowed

Maryland USA

Christian from

Paul Tetter

Yes

ALL INFORMATION

Under First

4405 Belwood Ave

Fell's Bldg

ap 11

Richard H Paul

7/1/51

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6628		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6628	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) KERNAN, M. JEANNETTE			2. DATE AND HOUR OF DEATH JULY 10, 1967 8:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 25-41 D. STREET ADDRESS (If rural, give location) 1000 S CATON AVE (JENKINS HOSPITAL)		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 07/01/84	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months Days Hours Min. 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER (RETIRED)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME PHILLIP E KERNAN			14. MOTHER'S MAIDEN NAME CATHERINE FITZGERALD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 220 46 5107		
17. INFORMANT ST AGNES HOSPITAL/CATON & WILKENS AVE.			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E903.17 Complication of fractured hip and old age pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cardiac failure			CAUSE OF DEATH Complication of fractured hip and old age pneumonia INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOSPITAL		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Jenkins Memorial Hospital			21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) 6-5-67 10 AM		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? Fall against wall in bath room slid to the floor		
22. I certify that XX (this hospital) attended the deceased from 06/05 19 67 to 07/10/ 19 67 , that XX (we) lost saw the deceased alive on 07/10/67 19 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (we) (did) (XXX) view the body after death.					
23A. SIGNATURE Nick Bahr			23B. DATE SIGNED 07/10/67		
23C. PHYSICIAN'S NAME (Type) NICKBAHR			23D. ADDRESS BALTO., MD. 21229		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/13/67		
24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE RECEIVED JUL 11 1967			25B. NAME OF REGISTRAR Robert E. Farkas		
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			ADDRESS		

AT 10:00

BY 10:00

8:15 P

JULY 10, 1962

RECEIVED BY JENNIFER

INVESTIGATOR

10:00 AM

10:00 AM (JENNIFER HOSPITAL)

STATION 1000

STATION 1000

CATHERINE FITZGERALD

220 46 ST ST. JAMES HOSPITAL 1000 10:00 AM

ST. JAMES HOSPITAL

10:00 AM (JENNIFER HOSPITAL)

10:00 AM (JENNIFER HOSPITAL)

10:00 AM (JENNIFER HOSPITAL)

10:00 AM (JENNIFER HOSPITAL)

10:00 AM (JENNIFER HOSPITAL)

10:00 AM

ST. JAMES HOSPITAL

10:00 AM

ST. JAMES HOSPITAL

10:00 AM

ST. JAMES HOSPITAL 10:00 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67. 6629
BIRTH NO. 67. 6629		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Barnes, Marie Gertrude</i>		
2. DATE AND HOUR OF DEATH		<i>8:45 pm on 7/10/67</i> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <i>Md.</i> B. COUNTY <i>Baltimore City</i> C. CITY OR TOWN <i>Baltimore</i> (If outside city limits, write RURAL and give township) <i>53-00</i>		
<i>44 Union Memorial Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>7736 Beverly Ave.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>10-29-93</i>	9. AGE (In years last birthday) <i>73</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Frederick Rausch</i>		14. MOTHER'S MAIDEN NAME <i>Nanette Auer</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-18-2069</i>		17. INFORMANT <i>Mrs. Audrey Greenwood</i> ADDRESS <i>(Same)</i>
18. <i>733.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES		(A) DUE TO <i>Cardiac Arrest</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <i>Congestive Heart Failure</i>		
		(C) <i>Atrial Fibrillation - ASCVD</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>7/8</i> 19 <i>67</i> to <i>7/10</i> 19 <i>67</i> . the (I) (we) last saw the deceased alive on <i>7/10</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Barry J. Wicker</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/10/67</i>
23C. PHYSICIAN'S NAME (Type) <i>Ossman</i>		23D. ADDRESS <i>Union Memorial Hosp.</i>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>7/13/67</i>	24C. NAME OF CEMETERY or CREMATORY <i>Moreland Mem. Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 11 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i> ADDRESS

10-57-73
Maryland
Nantux Ave

Actual Filing -
Competition from Future
Caroline Arrest

Grandfather

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6630	
67 6630				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		ARTHUR C. MEEKINS		7-10-67 8:37 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33			A. STATE MARYLAND		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			1361 WINSTON AVENUE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	MARRIED	12-08-18	48	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Personel Director		St. Agnes Hospital		Baltimore Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Austin V. Meekins			Edna E. Crowe		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		unknown		Dorothy R. Meekins Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)			(A) Cardio-pulmonary failure		
ANTECEDENT CAUSES			(B) Mitral and Aortic Valve disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Rheumatic Fever		
II			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Cardiac Cirrhosis		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6-1-67		Aortic + Mitral Valve Replacement		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (H) (this hospital) attended the deceased from 5-28 19 67 to 7-10 19 67 , that (I) (we) last saw the deceased alive on 7-10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
L.C. Parks MD				7-10-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Leon C. Parks				Johns Hopkins Hosp Bldg., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		7-13-67		Moreland Memorial	
				Baltimore Maryland	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 11 1967		Robert E. Parkers		Leonard J. Ruck Inc. 5305 Harford Rd. 21214	

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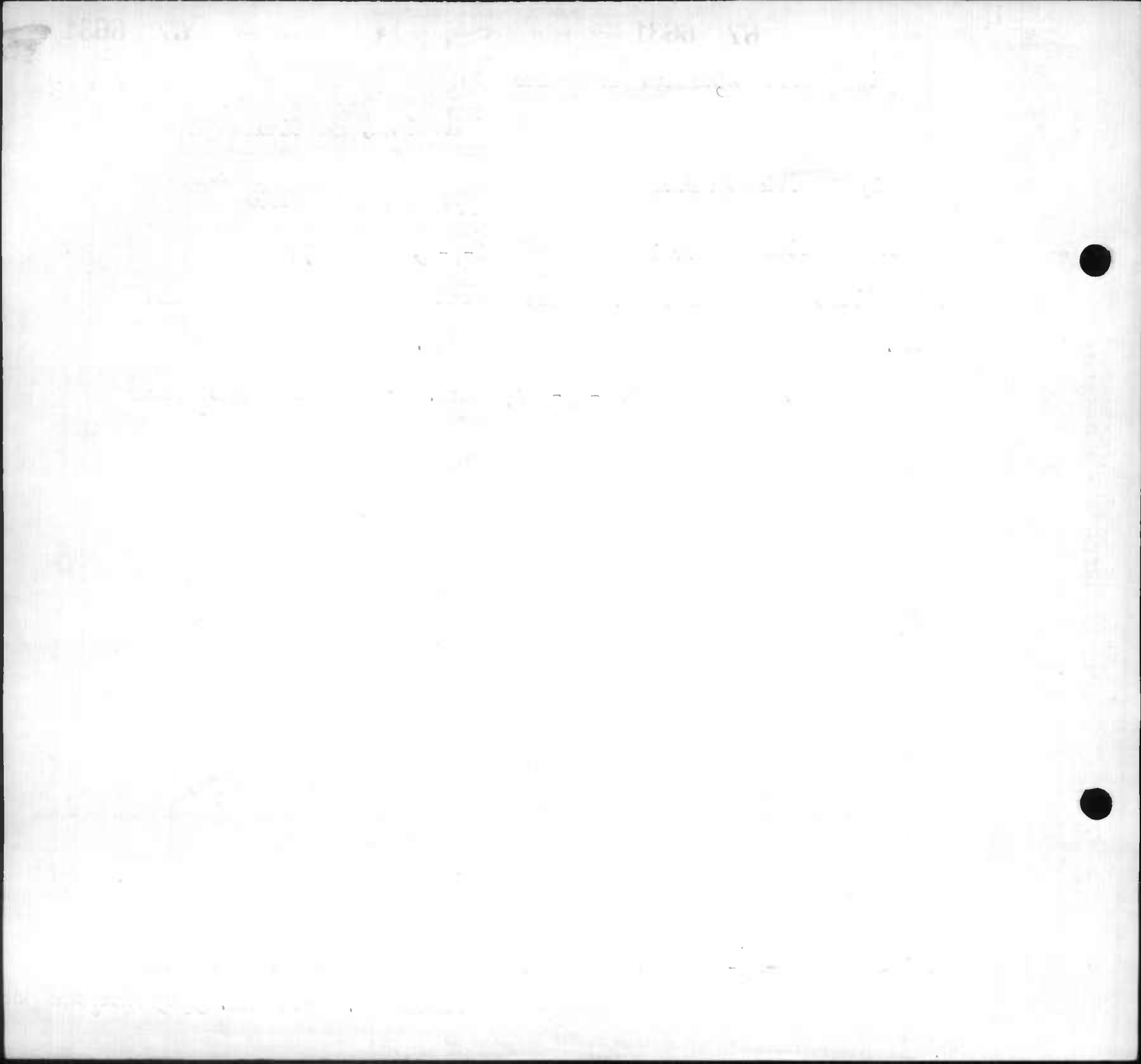
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 6631					REGISTERED NO. 67 6631				
M.E. CASE NO.					DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>Jim Vincent Vincenzo Marazzano</i>					2. DATE AND HOUR OF DEATH <i>7-9-67 8:00 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>2503 Albion Avenue</i>					A. STATE <i>Maryland</i> , B. COUNTY <i>Baltimore City</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					D. STREET ADDRESS (If w/o, give location) <i>27-01 3711 Parkside Drive</i>				
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>8-4-95</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe Miller</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Unk.</i>			14. MOTHER'S MAIDEN NAME <i>Unk.</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service) <i>Yes WWI</i>			16. SOCIAL SECURITY NO. <i>215-07-7619</i>		17. INFORMANT <i>Mrs. Jessie Morazzano</i>		ADDRESS <i>Same</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i>			CAUSE OF DEATH (A) DUE TO <i>Coronary Arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO			(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pulmonary Emphysema</i>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>7-5-1967</i> to <i>7-8-1967</i> , that (I) (we) last saw the deceased alive on <i>7-5-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Sebastian Russo</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7-9-67</i>			
23C. PHYSICIAN'S NAME (Type) <i>SEBASTIAN RUSSO</i>				23D. ADDRESS <i>5017 Hartford Rd</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-13-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley</i>		24D. LOCATION (City, town or county) (State) <i>Baltimore Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 11 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. 5305 Hartford Road</i>					



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
67 6632					Registered No. 67 6632				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) XXJESSE MILTON MCGRAW					2. DATE AND HOUR OF DEATH 7 9 67 6:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL WILKENS & CATON BALTO 29 MD					A. STATE MARYLAND				
(If not in hospital or institution, give street address or location)					B. COUNTY 9.9.6				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) GREENHAVEN 52-00				
					D. STREET ADDRESS (If rural, give location) RT 3 BOX 303 205ST				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 04 23 09	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER			10B. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME CLEVELAND MCGRAW					14. MOTHER'S MAIDEN NAME Sizzel				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 302-03-6608		17. INFORMANT ADDRESS ST AGNES HOSPITAL RECORDS				
18. 7-20-71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASEVD					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that X (this hospital) attended the deceased from 7 3 67 to 7 9 67 , that X (we) last saw the deceased alive on 7 9 67 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (did not) view the body after death.									
23A. SIGNATURE George S. Patrick M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/9/67		
23C. PHYSICIAN'S NAME (Type) George S. Patrick					23D. ADDRESS Baltimore Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/67		24C. NAME OF CEMETERY OR CREMATORY Worlegs Run Cemetery		24D. LOCATION (City, town, or county) (State) Scioto, Co. Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1967		25B. NAME OF REGISTRAR Robert E. Tolson		25C. FUNERAL DIRECTOR ADDRESS Robert P. Ware Singleton Funeral Home/Glen Burnie, Md.					

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XXXX JERRY HILTON HOGAN

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WHITE HARBEL

TRANSPORTATION TRUCK DRIVER

CLEVELAND

ST AGNES HOSPITAL RECORDS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67. 6633					Registered No. 67. 6633		X		
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Harding, Ada C.					2. DATE AND HOUR OF DEATH 7-9-67 3:30 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 1409 Midvale Rd. 21228 B. COUNTY Belts. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE 53-00 D. STREET ADDRESS (If rural, give location)				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED Widowed	8. DATE OF BIRTH 12-19-86	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER			10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME LOIS SCHWEARING					14. MOTHER'S MAIDEN NAME MARGARET WOLFE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Thomas Harding - 1409 Midvale Ave				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 7467 Cerebral Vascular Accident Hypertension Atherosclerotic Nephrosclerosis Uremia					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from June 1967 to 9 July 1967 , that (I) (we) lost saw the deceased alive on 9 July 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William J. Bryson					23B. DATE SIGNED 11 July 67				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS 6605 Edmondson Ave				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		7-13-67		Baltimore Md.		Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS		
JUL 11 1967			Robert E. Taylor		Julius Conway		B.H. - Catonsville, Md.		

Handwritten notes at the top left, possibly a title or date.

Handwritten notes at the top right, possibly a title or date.

Main body of handwritten text, appearing to be a list or series of entries, possibly related to a survey or inventory. The text is faint and difficult to read.

FUNERAL DIRECTOR: IMPORTANT

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RELEASED AS NON-MED BY DR. KORNBLUM, OF M.E. OFFICE

BIRTH NO. 57 6634		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6634	
M.E. CASE NO. 57 6634		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BONICCONTI, JEANETTE		2. DATE AND HOUR OF DEATH 7/2/67 - 8:40 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
5. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		6. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
7. STREET ADDRESS (If rural, give location) 1622 TOWNE ST.		8. DATE OF BIRTH 9-9-1915			
9. SEX F		10. RACE W		11. AGE (In years lost birthday) 51	
12. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED		13. DATE OF BIRTH		14. AGE (In years lost birthday)	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY		17. BIRTHPLACE (State or foreign country)	
18. FATHER'S NAME JOSEPH CRAIG		19. MOTHER'S MAIDEN NAME		20. CITIZEN OF WHAT COUNTRY? US	
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		22. SOCIAL SECURITY NO.		23. INFORMANT ADDRESS	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH MYOCARDIAL INFARCTION		25. CAUSE OF DEATH		26. INTERVAL BETWEEN ONSET AND DEATH 2-6 hrs	
27. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
29. DATE OF OPERATION		30. CONDITION FOR WHICH OPERATION WAS PERFORMED		31. AUTOPSY? (Yes or No) No	
32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
35. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		36. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		37. HOW DID INJURY OCCUR?	
38. I certify that (X) (this hospital) attended the deceased from July 2 1967 to July 2 1967 , that (X) (we) last saw the deceased alive on July 2 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
39. SIGNATURE John T. Flaherty		40. DATE SIGNED July 2, 1967			
41. PHYSICIAN'S NAME (Type) JOHN T. FLAHERTY		42. ADDRESS JOHNS HOPKINS HOSPITAL OF MARYLAND			
43. BURIAL CREMATION, REMOVAL (Specify) 7-11-67		44. NAME OF CEMETERY or CREMATORY		45. LOCATION (City, town, or county) (State)	
46. DATE REC'D BY HEALTH DEPT. JUL 12 1967		47. NAME OF REGISTRAR Robert E. Fisher, M.D.		48. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL	
49. ADDRESS		50. ADDRESS		51. ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6635	
BIRTH NO. 67-12820 67 6635 CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Baby Boy Chassin			2. DATE AND HOUR OF DEATH July 6, 1967 3⁵⁰ A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 21211 13-08		
			D. STREET ADDRESS (If rural, give location) 3600 Hooper AVE		
5. SEX Male	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) N.B.	8. DATE OF BIRTH July 3, 1967	9. AGE (In years last birthday) 3	If Under 1 Yr. Months: Days: Hours: Min. 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Phillip M. Chassin			
14. MOTHER'S MAIDEN NAME AVIS ARLENE Fitzer		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Mother		ADDRESS SAME	
18. 773.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Distress Syndrome			CAUSE OF DEATH Respiratory Distress Syndrome		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from July 3, 1967 to July 6, 1967 , that (1) (we) last saw the deceased alive on July 6, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles Janner M.D.				23B. DATE SIGNED July 6, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-7-67		24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	
25D. ADDRESS					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6636	
BIRTH NO. 67-12007 67 6636					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Baby boy Miller			2. DATE AND HOUR OF DEATH 6-17-67 10⁵⁵ a M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University of Maryland Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21215 7th D		
			D. STREET ADDRESS (If rural, give location) 3516 Manchester Ave		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) _____	8. DATE OF BIRTH 6-16-67	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 23 Hours: 19 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US A
13. FATHER'S NAME James G. Miller			14. MOTHER'S MAIDEN NAME Jeanette Jackson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure			CAUSE OF DEATH (A) DUE TO Hyaline Membrane Disease		INTERVAL BETWEEN ONSET AND DEATH 15 min
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO Prematurity		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Skripkus			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) Aldona Skripkus			23D. ADDRESS University of Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-7-67	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR JUL 12 1967		25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6637	
BIRTH NO. 67-12414 67 6637					
CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) BABY BOY WRIGHT			2. DATE AND HOUR OF DEATH 9.00 a.m. 6-24-67 9.00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSPITAL			A. STATE MD B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2604 Picpoint St		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6-23-67	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min. 20 04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harrell Johnson			14. MOTHER'S MAIDEN NAME Joan Marie Wright		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 767-51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH (A) Pulmonary atelectasis & cardiac insufficiency DUE TO (B) Prematurity (2lb. 9oz.) DUE TO (C) Ante-partum hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that he (this hospital) attended the deceased from 12.56 p.m. 6-23-1967 to 6.24. 1967 , that he (we) last saw the deceased alive on 6.24. 19.67 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) did not view the body after death.					
23A. SIGNATURE Harold Brenner			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-24-67
23C. PHYSICIAN'S NAME (Type) HAROLD BRENNER			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-7-67		24C. NAME of CEMETERY or CREMATORY	
				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

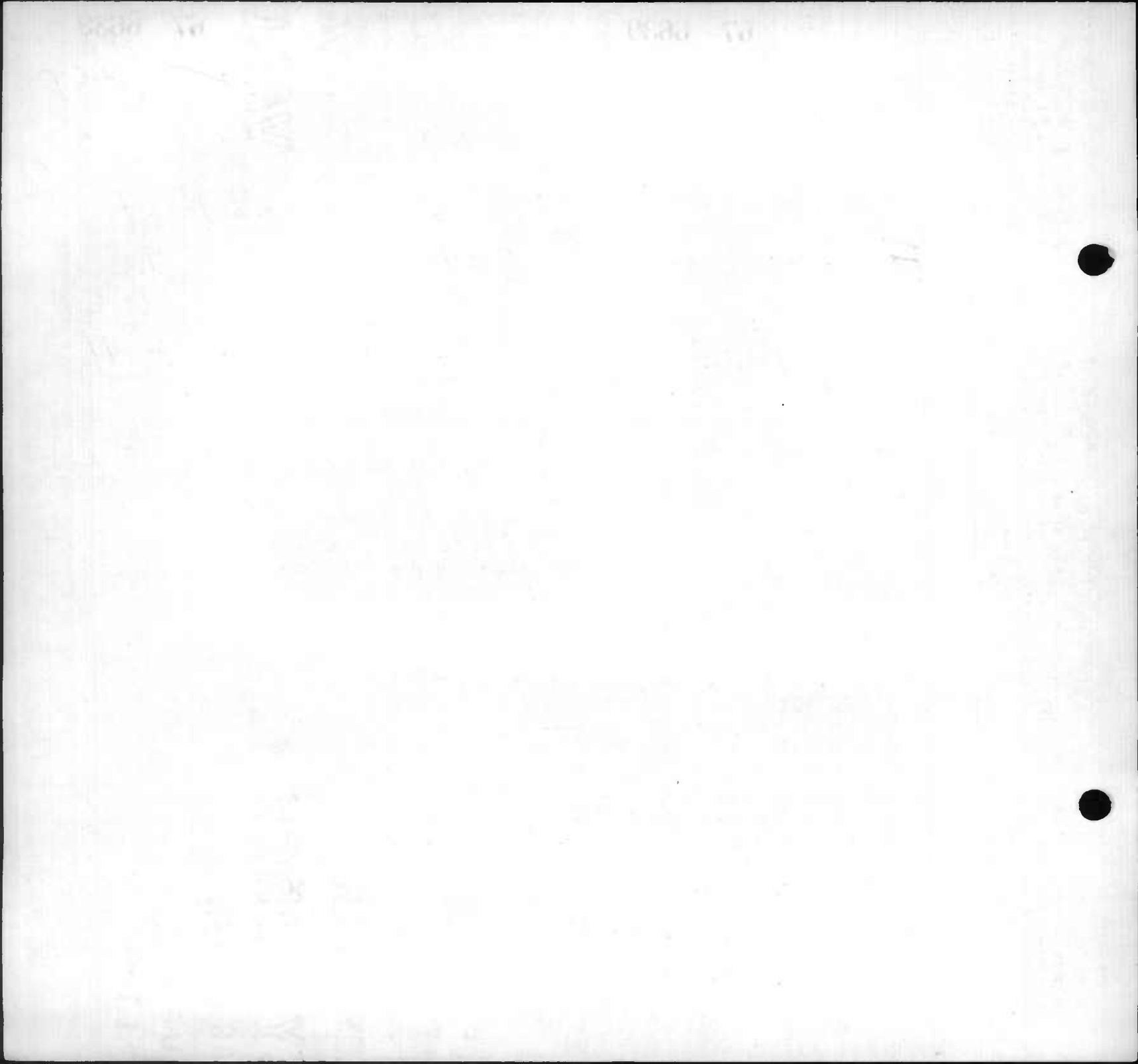
BIRTH NO. 67-12986 67 6638		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6638	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY BOY BAYNARD		JUNE 26, 1967 4:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY OF MARYLAND HOSPITAL		A. STATE MARYLAND B. COUNTY G.A.C.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERNA PARK 52-00			
		D. STREET ADDRESS (If rural, give location) RT. 1 BOX 170 D			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 5/26/67	9. AGE (In years last birthday) 1 month	10. Under 1 Yr. Months: Days: Hours: Min. 1 0
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ELIJAH BAYNARD JR.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS PARENTS STATE AS ABOVE	
18. 561,51		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASPIRATION PNEUMONIA		(A) DUE TO		3 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Small bowel obstruction secondary to gastroenteritis		1 month (30 days)	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/26/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ASPIRATION OF GUT THROUGH UNUSUAL		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NO		21E. INJURY OCCURRED While At Work <input type="checkbox"/> NO Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NO	
22. I certify that (I) (this hospital) attended the deceased from MAY 26 1967 to JUNE 26 1967 , that (I) (we) last saw the deceased alive on JUNE 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alfredo F. Garcia Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/26/67	
23C. PHYSICIAN'S NAME (Type) ALFREDO F. GARCIA JR. M.D.		23D. ADDRESS UNIVERSITY BOARD OF HOSPITALS			
24A. BURIAL CREMATION, REMOVAL (Specify) 7-7-67		24B. DATE 7-7-67			
24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND		24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR ALFREDO F. GARCIA JR.		25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-11865 67 6639		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6639	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type of final)		2. DATE AND HOUR OF DEATH			
Baby girl Bowey		6-26-67 1140 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
University of Maryland Hosp.		Md Baltimore X			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore 3-02			
		D. STREET ADDRESS (If rural, give location)			
		165 Albermarle St			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
F	Negro	newborn	6-19-67	7	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Baltimore, Md	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Leroy Bowey			Juanita Bowey Hill		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				1	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Airway obstruction Aspiration		2 h.	
		(B) DUE TO Tracheoesophageal fistula status post operative			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6-20-67		Tracheoesophageal fistula		✓	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-26 1967 to 1967 that (I) (we) last saw the deceased alive on 6-26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Carlos Boetsch, M.D.				6-26-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr Carlos Boetsch		University of Maryland Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY (If not in Baltimore City, give location) (State)	
		7-7-67		UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 12 1967		Robert E. Fisher, M.D.		HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6640	
BIRTH NO. 67-12467 67 6640		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Grien, Baby Girl</u>		2. DATE AND HOUR OF DEATH <u>6-28-67</u> <u>12⁴⁰pm</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>-</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>924 N. Gilmore St</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>6-27-67</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min. <u>22 8</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Willie Bernard Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Grasty</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Chot</u> ADDRESS	
18. <u>773.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <u>Prematurity</u> (B) <u>Respiratory Distress Synd - Life</u> (C)		INTERVAL BETWEEN ONSET AND DEATH <u>Life</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>-</u>		22. I certify that (this hospital) attended the deceased from <u>3⁴⁸pm</u> <u>6-27</u> 19 <u>67</u> to <u>12⁴⁰pm</u> <u>6-28</u> 19 <u>67</u> , that (we) last saw the deceased alive on <u>6-28</u> 19 <u>67</u> and that in (aur) apinlan death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.			
23A. SIGNATURE <u>Edward J. Ruley, MD.</u>		23B. DATE SIGNED <u>6-28-67</u>		23C. PHYSICIAN'S NAME (Type) <u>Edward J. Ruley, MD.</u>	
23D. ADDRESS <u>University Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>7-7-67</u>		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>		24D. LOCATION (City, town, or county) <u>HOSPITAL DISPOSAL</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1967</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fairley, MD.</u>		25C. FUNERAL DIRECTOR <u>6650</u>		25D. ADDRESS	

03-06-40

03-06-40

12-24

0-25-40

Gover, Baby Girl

MR

Baltimore

12-24 N. Adams St

University Hospital

Paul Negro New Name

0-25-40

MR

USA

Newborn

Class

MR

University

Respiratory Distress - 1-2

MR

MR

MR

0-25-40

0-25-40

Edward J. Rusey, MD

University Hospital

0-25-40

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6641	
BIRTH NO. 67-12608 67 6641				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) BABY GIRL HICKS				6.18.67 9:40 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
UNIVERSITY OF BALTIMORE HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				D. STREET ADDRESS (If rural, give location)	
				1730 Baltow St #21217	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
F	N	—	6.17.67	—	13 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
—			BALTIMORE		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Harvey Lee Jenkins			Lillie Louise Hicks		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
—			—		—
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) PULMONARY ATLECTASIS		
ANTECEDENT CAUSES			(B) Immature brain centers		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Prematurity (wt=800grams)		
II			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			—		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
—		—		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
—		—		—	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
—		—		—	
22. I certify that (this hospital) attended the deceased from 6.17.67 19 to 6.18.67 19 that (we) last saw the deceased alive on 6.18.67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Harold Brenner				6.18.67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Harold Brenner				University of Maryland Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
—		7-7-67		—	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 12 1967		Robert E. Farley, M.D.		MORTUARY SERVICE - BCHD	

1782 50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

67. 6642 CERTIFICATE OF DEATH

Registered No. 67 6642

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Mr. William A. Cavey, Sr

2. DATE AND HOUR OF DEATH

7-10-67 10 05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

34 Bow Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Balto.

D. STREET ADDRESS

(If rural, give location)

2000 Hollins Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2-24-76

9. AGE (In years)

91

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

TREE TRIMMER

10B. KIND OF BUSINESS OR INDUSTRY

Utility Co.

11. BIRTHPLACE (State or foreign country)

Ellicott City Md.

12. CITIZEN OF WHAT COUNTRY?

yes.

13. FATHER'S NAME

John Cavey

14. MOTHER'S MAIDEN NAME

O. H. Krown

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

212-05-5690

17. INFORMANT

Alma Cavey

ADDRESS

2000 Hollins St.

18.

7-22-117260X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Arteriosclerotic C.V. Dis

DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

?

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes, Nephrosclerosis, Hepatic insuff.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At Work ☐ Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 6 1967 to July 10 1967, that (I) last saw the deceased alive on July 10 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Lester A. Wall Jr

M.D.

Attending Phys.

Med. Director

Staff Phys.

23B. DATE SIGNED

7/10/67

23C. PHYSICIAN'S NAME (Type)

LESTER A. WALL JR

23D. ADDRESS

1039 St Paul St. Baltimore 2

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

7-14-67

24C. NAME OF CEMETERY or CREMATORY

Good Shepherd

24D. LOCATION

Howard CTy

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 12 1967

25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

Geo. L. Schwab

25D. ADDRESS

2101 Frederick Ave.

Washington, D.C.

John, Washington, D.C.

John A. Washington
Washington, D.C.

Washington, D.C.
1845

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6643		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6643	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Gray, Francis</u>				7-10-67 9:00P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Provident Hospital, Inc. Baltimore, Maryland 21217</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		<u>15-02</u>	
				D. STREET ADDRESS (If rural, give location) <u>1923 W. North Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>4-2-01</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Gray</u>				14. MOTHER'S MAIDEN NAME <u>Maria ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>27-20-0820</u>		17. INFORMANT <u>Elaine</u> (Daughter)		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary congestion</u> CAUSE OF DEATH (A) DUE TO <u>CVT</u> (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-4-67</u> 19 to <u>7-10-67</u> 19, that (I) (we) last saw the deceased alive on <u>7-10-67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jared</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-11-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jared</u>				23D. ADDRESS M.D. <u>1514 Division Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/13/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Archives Mem. Pk. Archives</u>		24D. LOCATION (City, town, or county) (State) <u>Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Earl Gilmore</u>		ADDRESS <u>1827 W. North Ave.</u>	

Michael

James
 27-11-1850
 Thomas
 27-11-1850

James
 27-11-1850
 Thomas
 27-11-1850

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6644																																																	
BIRTH NO. 67 6644		CERTIFICATE OF DEATH																																																			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DEVESE JARRETT		2. DATE AND HOUR OF DEATH July, 9, 67. 5:00 AM																																																	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE _____ B. COUNTY _____		M. 28-02																																																	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE Inc BELVEDERE AVE AT GREENSPRING		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore																																																			
		D. STREET ADDRESS (If rural, give location) 5601 Gwynn Oak Avenue																																																			
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 12.20.97	9. AGE (In years lost birthday) 70yr.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.																																																
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician		10B. KIND OF BUSINESS OR INDUSTRY Amer. Gen. Corp.		11. BIRTHPLACE (State or foreign country) Baltimore County																																																	
13. FATHER'S NAME William D. Devese		14. MOTHER'S MAIDEN NAME Lily Howard		12. CITIZEN OF WHAT COUNTRY? AMERICA.																																																	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 216-07-2832		17. INFORMANT ADDRESS Ida Devese, 5601 Gwynn Oak Avenue #7																																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">I</td> <td colspan="2" style="text-align: center;">CAUSE OF DEATH</td> <td colspan="2" style="text-align: center;">INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr> <td colspan="2" style="text-align: center;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</td> <td colspan="2" style="text-align: center;">(A) DUE TO</td> <td colspan="2" style="text-align: center;">6 days.</td> </tr> <tr> <td colspan="2" style="text-align: center;">(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</td> <td colspan="2" style="text-align: center;">Respiratory failure.</td> <td colspan="2"></td> </tr> <tr> <td colspan="2" style="text-align: center;">ANTECEDENT CAUSES</td> <td colspan="2" style="text-align: center;">(B) DUE TO</td> <td colspan="2" style="text-align: center;">10 yrs.</td> </tr> <tr> <td colspan="2" style="text-align: center;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</td> <td colspan="2" style="text-align: center;">EMPHYSEMA.</td> <td colspan="2"></td> </tr> <tr> <td colspan="2" style="text-align: center;">(C) _____</td> <td colspan="2"></td> <td colspan="2"></td> </tr> <tr> <td colspan="6" style="text-align: center;">II</td> </tr> <tr> <td colspan="6" style="text-align: center;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</td> </tr> </table>						I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		6 days.		(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Respiratory failure.				ANTECEDENT CAUSES		(B) DUE TO		10 yrs.		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		EMPHYSEMA.				(C) _____						II						OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																																																	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?																																																	
22. I certify that (I) (this hospital) attended the deceased from 7/12/67 19 67 to 7/9/ 19 67 , that (I) (we) last saw the deceased alive on 7/9/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																																																					
23A. SIGNATURE Intiaz Hamid				23B. DATE SIGNED																																																	
23C. PHYSICIAN'S NAME (Type) INTIAZ HAMID				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE, BALTIMORE MD																																																	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-12-67		24C. NAME OF CEMETERY or CREMATORY Western Cemetery																																																	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967																																																			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost Funeral Chapel 4600 Liberty Heights Ave.																																																			

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67 6645

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6645

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DONNA AMMON

2. DATE AND HOUR PRONOUNCED DEAD

July 9, 1967 7:25 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Pennsylvania

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Media

D. STREET ADDRESS (If rural, give location)

711 N. Providence Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

SEPT. 22 1956

9. AGE (In years last birthday)

10

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PHILA. PA.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

ROBERT DAVID AMMON

14. MOTHER'S MAIDEN NAME

CATHERINE AMMON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

MR. RICHARD AMMON (Uncle)

ADDRESS RT 4, Box 48 A ANNAPOLIS, Md.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Contusion of brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fracture of pelvis and ribs

(C)

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Road

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Old Millbottom road and Rt. 50

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

7 3 67 12:45

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

passenger in rear seat of auto-tractor trailer collision

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S

NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

23A. BURIAL CREMATION, REMOVAL (Specify)

Removal - Burial

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

GLENWOOD MEM. CEM.

23D. LOCATION

BROOMALL

PA.

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

BEALL

ADDRESS

1212 WEST ST. ANNAPOLIS, MD.

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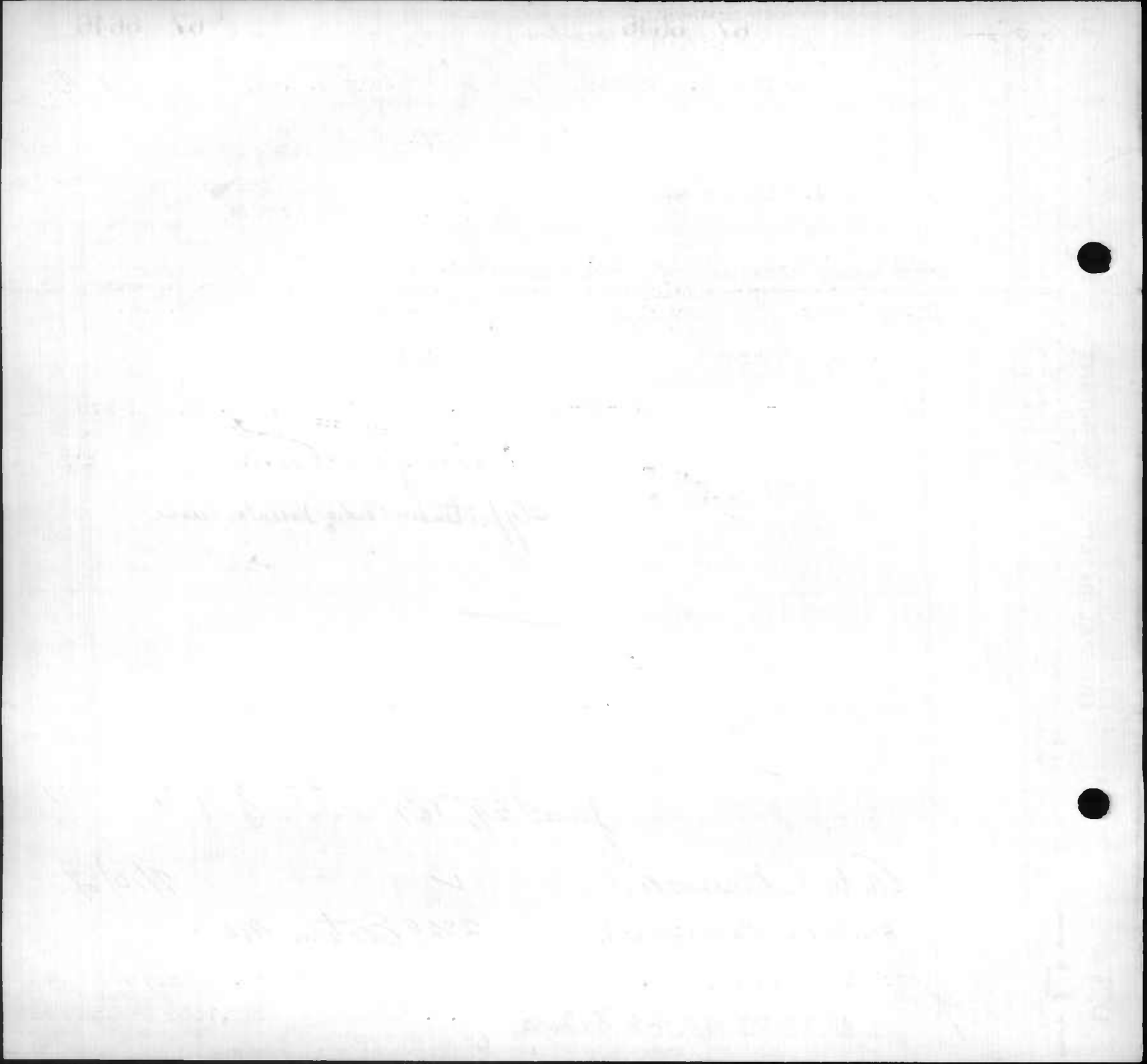
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67. 6646		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67. 6646	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
				LOUIS Z. BONCZEK			
2. DATE AND HOUR OF DEATH				July 9, 1967 1 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 7 S. Ellwood Avenue				Maryland			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
D. STREET ADDRESS (If rural, give location)				7 S. Ellwood Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Male	White	Married	7/22/04	62			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Interviewer			Employment Security		Maryland		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Anthony Bonczek				Antoinette Bednarska			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		218-03-0098		Mrs. Vera Bonczek		7 S. Ellwood Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from January 5, 1967 to July 9, 1967, that (I) (we) last saw the deceased alive on June 29, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Andrew Tunkowski						7/10/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Andrew Karkowski				2529 Eastern Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/13/67		St. Stanislaus		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 12 1967		Robert E. Tarkenton		M.F. SADOWSKI & SONS, 1808 EASTERN AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

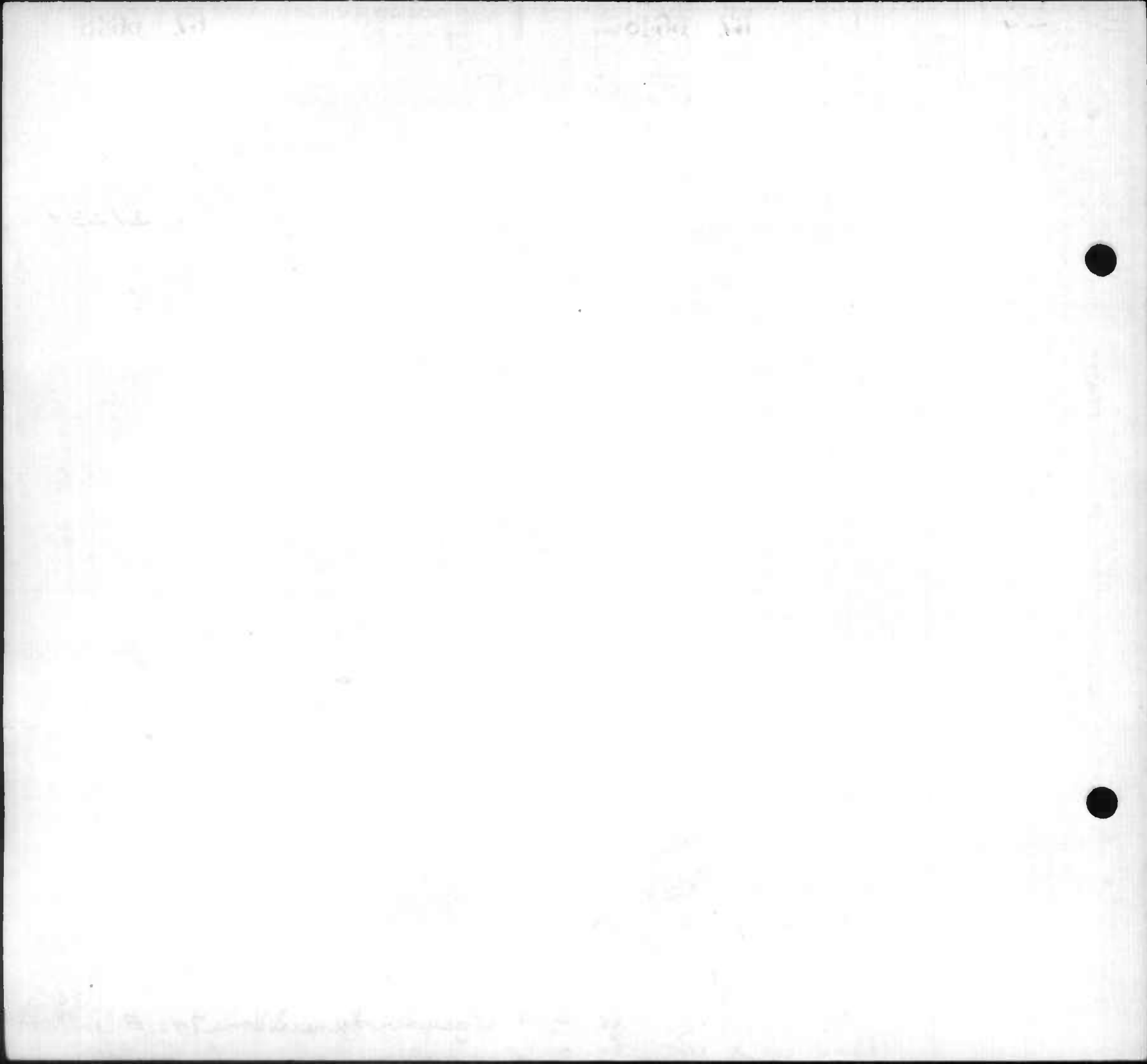
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6647	
BIRTH NO. 67 6647		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED Maywell - David			
2. DATE AND HOUR OF DEATH 7/11/67 1:55 P.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Dukeland Nursing Home 90 1501 Dukeland St.		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4-01 D. STREET ADDRESS (If rural, give location) 211 - Gay St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/18/66	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Dukeland nursing Home ADDRESS 1501 Dukeland St.	
18. 443X I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) HYPERTENSIVE ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-4 1966 to 7-11 1967 , that (I) (we) last saw the deceased alive on 7-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas W. Harris		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-11-67	
23C. PHYSICIAN'S NAME (Type) THOMAS W. HARRIS		23D. ADDRESS 1824 W FRANKLIN ST			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/67		24C. NAME OF CEMETERY OR CREMATORY Green Haven Cem.	
24D. LOCATION (City, town, or county) (State) MD		24E. FUNERAL DIRECTOR John J. Brown & Son Inc.			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR John J. Brown & Son Inc.		25C. ADDRESS 931 Hollins St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67. 6648		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67. 6648	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John S. Englehardt		2. DATE AND HOUR OF DEATH 7-9-67 6:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-05 D. STREET ADDRESS (If rural, give location) 7617 MARS AVE 21234			
5. SEX M	6. RACE W	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3-5-87	9. AGE (In years last birthday) 80	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dredger		10B. KIND OF BUSINESS OR INDUSTRY Arundel Corp.		11. BIRTHPLACE (State or foreign country) md.	
13. FATHER'S NAME Henry Englehardt			14. MOTHER'S MAIDEN NAME BARBARA YEAGER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-1025A		17. INFORMANT ADDRESS Mrs Katie Engelhardt 7617 Mars Avenue	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARCINOMA OF LUNG WITH METASTASIS (B) PNEUMONIA (C) Upper lobe Infiltrate of undetermined nature		INTERVAL BETWEEN ONSET AND DEATH years weeks unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10 JUNE 1967 to 9 JULY 1967 , that (I) (we) last saw the deceased alive on 9 JULY 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco Baltazar M.D.				23B. DATE SIGNED 7-9-67	
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR		23D. ADDRESS Church Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-12-1967		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Engelhardt Funeral Home 7401 Belair Road 36			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67. 6649	
CERTIFICATE OF DEATH				Registered No. 67. 6649	
BIRTH NO.		67. 6649		41	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LESTER V. MYERS, SR.		2. DATE AND HOUR OF DEATH July 8 1967 11:45 P	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY WESTMINSTER		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Westminster	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL 38		D. STREET ADDRESS (If rural, give location) Rt. 7 Box 196		E. ZIP CODE 21156	
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/20/26	9. AGE (In years last birthday) 41	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bulcher		10B. KIND OF BUSINESS OR INDUSTRY Wholesale Meats		11. BIRTHPLACE (State or foreign country) CARROLL CO, MD.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Mae Myers		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) YES W.W.II		16. SOCIAL SECURITY NO. 219-20-1869		17. INFORMANT MRS VIOLET S. MYERS, WESTMINSTER MD.	
18. 332X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) BRAIN Stem Compression with respiratory Failure		1 day	
ANTECEDENT CAUSES		(B) Cerebral Edema		1 day	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Internal Carotid Thrombosis 2 1/2 Days			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Harnuff				23B. DATE SIGNED 7/8/67	
23C. PHYSICIAN'S NAME (Type) Robert E. Taylor, M.D.				23D. ADDRESS Westminster, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/67		24C. NAME OF CEMETERY or CREMATORY Pleasant Valley Cemetery Westminster Rd # 7, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md.	

LESTER, J. H. R. 2, 2A.

UNIVERSITY HOSPITAL

WATE WHITE

Wholesale meats

Meats

YES WWII

219-20-1847

Western Engineering and
Equipment
General

General

Yes

Higher

7/2/77

General

L-563

67 6650

BALTIMORE CITY HEALTH DEPARTMENT

67 6650

BIRTH NO. 67-10258

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DAVID

S.

LEONARD

2. DATE AND HOUR PRONOUNCED DEAD

July 10, 1967

4:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5029 Chalgrove Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 25, 1967

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

1 1/2

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Barry Leonard

14. MOTHER'S MAIDEN NAME

Sylvia Petty

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Barry Leonard 5029 Chalgrove Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Aspiration of Stomach Contents
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7 12 67

23C. NAME OF CEMETERY or CREMATORY

Glen Haven

23D. LOCATION

(City, town, or county)

(State)

Glen Burnie, A. A. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Mc Gully

130 E. Fort Ave.

WALBURY PRINTER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6651		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6651	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) JOHN W. BORUM			2. DATE AND HOUR OF DEATH JULY 3 1967 18:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 48			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NEW JERSEY B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) HOBOKEN D. STREET ADDRESS (If rural, give location) 216 RIVER ST.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 11/12/1887	9. AGE (In years last birthday) 80	10. Under 1 Yr. Months: Days: 11 Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SRAMAN		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME COLUMBUS BORUM			14. MOTHER'S MAIDEN NAME ELIZABETH LOWRY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 102-12-7283-A		17. INFORMANT Hosp. Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION 1/2 hour			INTERVAL BETWEEN ONSET AND DEATH 200 YEARS		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROSIS					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —					
19A. DATE OF OPERATION 6/21/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BENIGN PROSTATIC HYPERPLASIA		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/18/67 19 to 7/3 19 67 , that (I) (we) last saw the deceased alive on 7/3/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. M. Harrison				23B. DATE SIGNED 7/3/67	
23C. PHYSICIAN'S NAME (Type) C. M. HARRISON		23D. ADDRESS M.D. MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/67		24C. NAME OF CEMETERY or CREMATORY St Pauls Cemetery	
24D. LOCATION (City, town, or county) (State) Mathews Virginia		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967			
25B. NAME OF REGISTRAR A. G. E. F. F. F.		25C. FUNERAL DIRECTOR Lassahn Funeral Home			
25D. ADDRESS 7401 Belvoir Rd.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67, 6652		REGISTERED NO. 67, 6652	
RHEA				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SANTMYER, MARJORIE				2. DATE AND HOUR OF DEATH 7-9-67 9:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE INC.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) OWINGS MILLS 53-00 D. STREET ADDRESS (If rural, give location) 51 Tollgate Rd			
5. SEX F	6. RACE CAU	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH MAY 16 '41		9. AGE (In years last birthday) 26	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LEGAL SECT.		10B. KIND OF BUSINESS OR INDUSTRY LAWYER FIRM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH W. ZIGWAREN				14. MOTHER'S MAIDEN NAME RHEA HAUGH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 21638-3351		17. INFORMANT WAYNE Santmyer, Mother ADDRESS 51 Tollgate Rd. Owings Mills, Md.			
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Thromia				INTERVAL BETWEEN ONSET AND DEATH 30 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Chronic Pyelonephritis				DUE TO 20 mos			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus				DUE TO 12 yrs			
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? N/O (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) No		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> No		21F. HOW DID INJURY OCCUR? N/O			
22. I certify that (I) (this hospital) attended the deceased from 7-7-67 to 7-9-67 , that (I) (we) last saw the deceased alive on 7-9-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jeff Parker M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7-9-67			
23C. PHYSICIAN'S NAME (Type) JEFF PARKER				23D. ADDRESS SINAI HOSP BALT. INC.			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/12/67		24C. NAME OF CEMETERY OR CREMATORY LAKE VIEW MEM. PARK.		24D. LOCATION (City, town, or county) (State) Sykesville, Maryland.	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H. J. Eckhardt ADDRESS Owings Mills, Md.			

Baltimore

#1

MARRIED

27

216-38-2321

Robert H. Smith
1910-1980

Smith, Robert H.
1910-1980

Burial
H.T. Eckhardt
216/38-2321
Lake View Park, Baltimore, Maryland

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

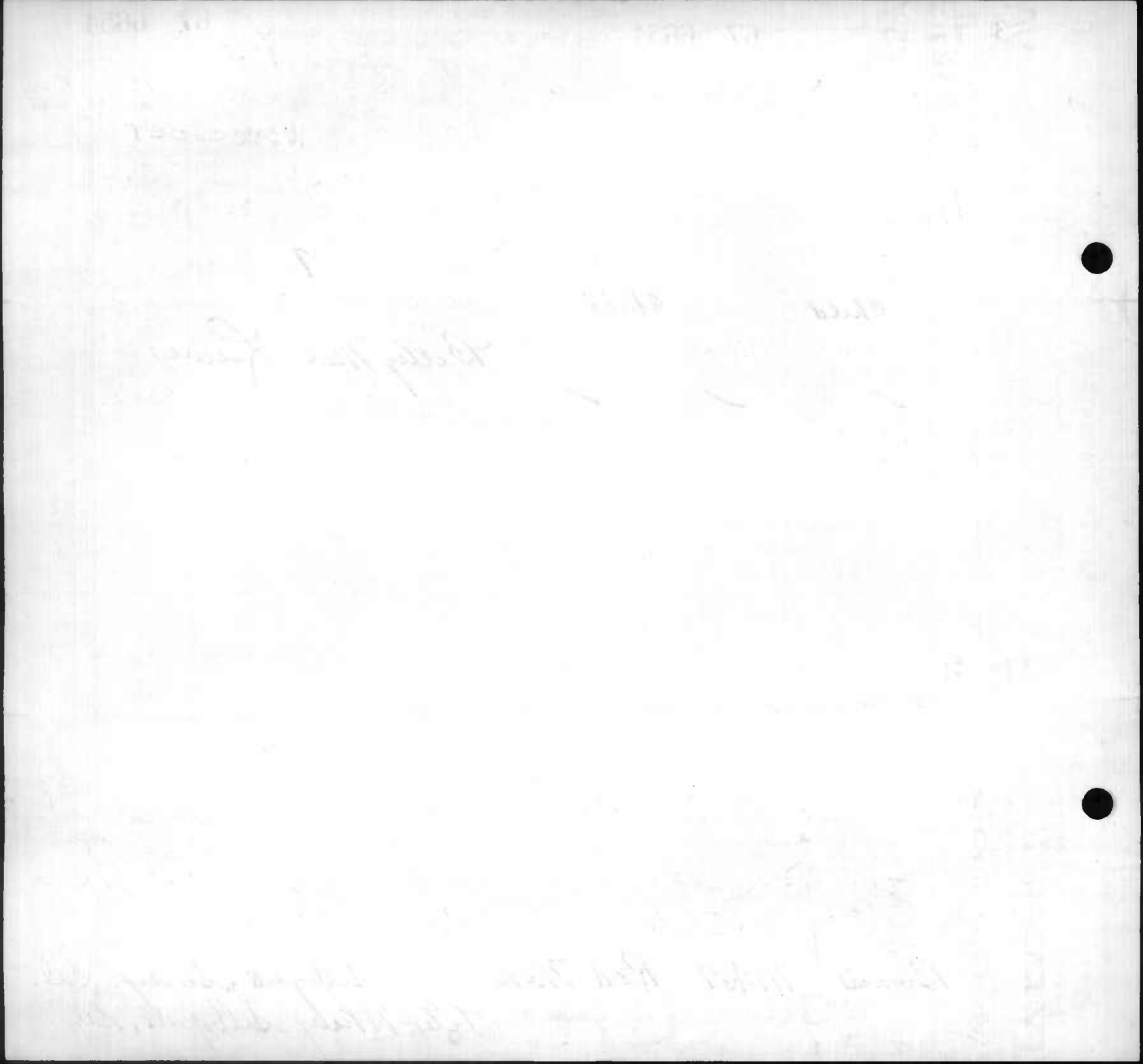
BIRTH NO. 67 6653		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6653	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Viola I. Cox</i>			7-9-67 1:23 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp</i>			A. STATE <i>Maryland</i> B. COUNTY <i>9.9. Co.</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN <i>Pasadena</i> (If outside city limits, write RURAL and give township) <i>52-00</i>		
5. SEX <i>F</i>			D. STREET ADDRESS (If rural, give location) <i>Rt. #10 Box #86 E. Laurel Dr.</i>		
6. RACE <i>White</i>			8. DATE OF BIRTH <i>4-1-05</i>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>			9. AGE (In years last birthday) <i>62</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>Va.</i>		
10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>			12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		
13. FATHER'S NAME <i>West Walden</i>			14. MOTHER'S MAIDEN NAME <i>Susan V. Kellum</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT ADDRESS <i>Mr. Joseph H. Cox Box 86 E. Rt. 10, Pasadena</i>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>metastatic cancer</i> DUE TO (B) <i>Cancer of ovary</i> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>Feb 67</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of ovary</i>		
20A. AUTOPSY? (Yes or No) <i>No</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from <i>7-7</i> 19 <i>67</i> to <i>7-9</i> 19 <i>67</i> , that (we) last saw the deceased alive on <i>7-9</i> 19 <i>67</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard H. Reed</i> M.D.			23B. DATE SIGNED <i>7-10-67</i>		
23C. PHYSICIAN'S NAME (Type) <i>Richard H. Reed</i> M.D.			23D. ADDRESS <i>1213 Light Street</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>7 12 67</i>		
24C. NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>			24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, A. A. Co. Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. Fasham</i>		
25C. FUNERAL DIRECTOR ADDRESS <i>Mc Cully 130 E. Fort Ave</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6654			
67 6654 CERTIFICATE OF DEATH													
BIRTH NO. 67 6654													
M.E. CASE NO.													
1. NAME OF DECEASED (Type of Print) <i>WILKERSON, Donnie Wilson</i>					2. DATE AND HOUR OF DEATH <i>8 July 1967 1:16 A.M.</i>								
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)								
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>University of Maryland Hosp.</i>					A. STATE <i>Maryland</i> B. COUNTY <i>Worcester Co.</i>								
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Bishopville 73.00</i>								
					D. STREET ADDRESS (If rural, give location) <i>Rt 1 Box 127</i>								
5. SEX <i>Male</i>		6. RACE <i>Cau.</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>18 May 1960</i>		9. AGE (In years last birthday) <i>7</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>child</i>					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Donnie Wilkerson</i>					14. MOTHER'S MAIDEN NAME <i>Billy Mae Lewis</i>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>✓</i>					16. SOCIAL SECURITY NO. <i>✓</i>		17. INFORMANT <i>Mother</i>			ADDRESS <i>same</i>			
18. <i>754.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Congenital heart disease Tetralogy of Fallot</i>										INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.													
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
19A. DATE OF OPERATION <i>6 July 1967</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Tetralogy of Fallot</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>22 June 1967</i> to <i>8 July 1967</i> that (I) (we) last saw the deceased alive on <i>8 July 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <i>Sanfor, Ch. D.</i>										23B. DATE SIGNED <i>8 July 1967</i>			
23C. PHYSICIAN'S NAME (Type) <i>Delfin S. Santos</i>					23D. ADDRESS <i>Univ. of Md. Hosp.</i>								
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/11/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Red Men</i>				24D. LOCATION (City, town, or county) (State) <i>Silbyville, Sussex Del.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1967</i>					25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>			25C. FUNERAL DIRECTOR <i>John H. Selbyville, Del.</i>					



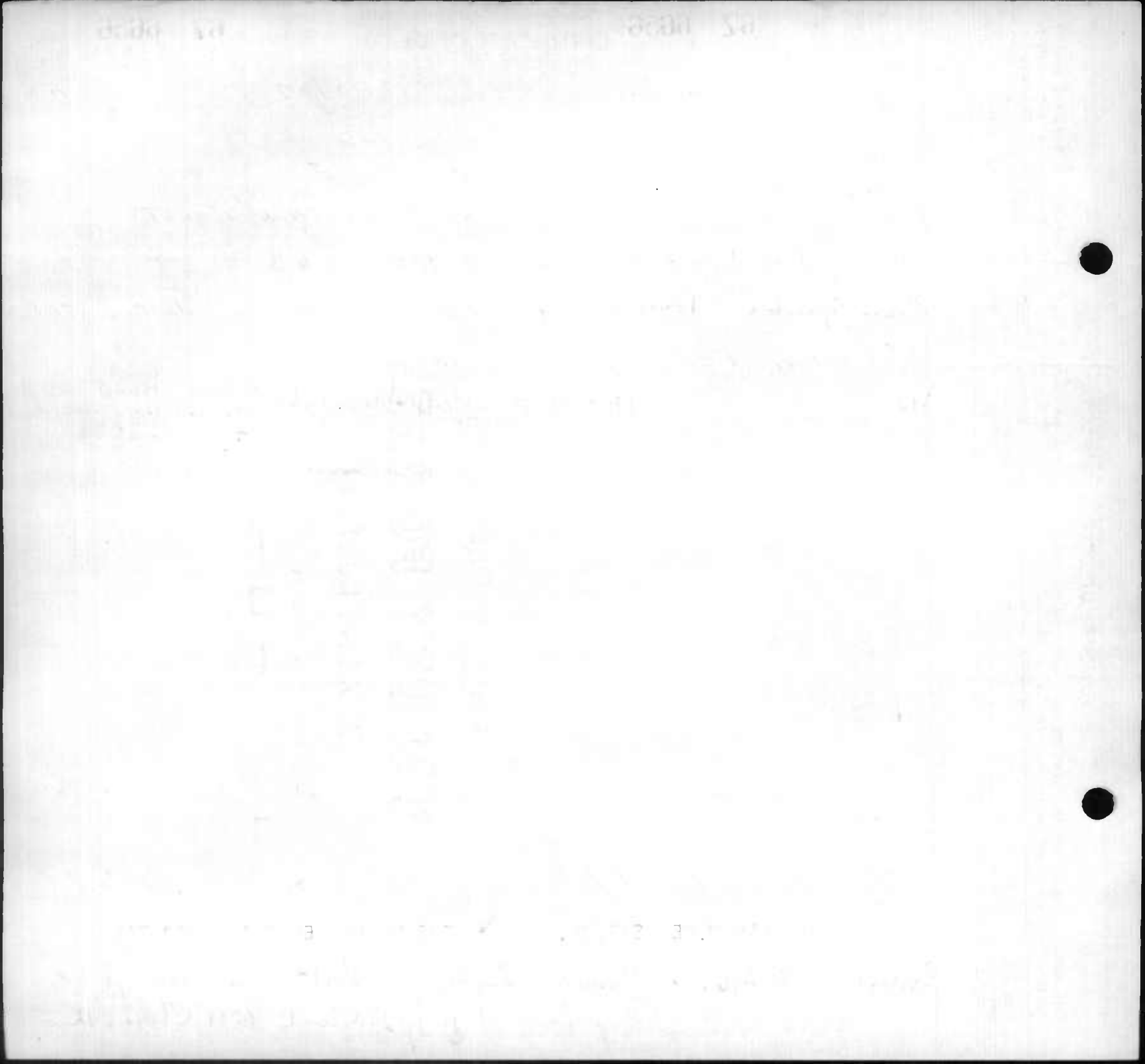
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-501		PAYNE 67 6655		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 6655	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PAYNE Ernst Waddington		2. DATE AND HOUR OF DEATH 2:45 PM 7/8/67		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION U.S.P.H. HOSPITAL				A. STATE Md.		B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville	
28				D. STREET ADDRESS (If rural, give location) 410 Neepier Rd #2853-00					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 7/27/19	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME OLIVER W. PAYNE SR.				14. MOTHER'S MAIDEN NAME Emma Meeth					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes U.S.A.F. WWII				16. SOCIAL SECURITY NO. 220-03-4100		17. INFORMANT ADDRESS HOSPITAL RECORDS			
18. 180X I				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) Metastatic Renal Cell C.A.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Ulcerative Gastro Enteritis					
				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE George H. Greidinger				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/9/67			
23C. PHYSICIAN'S NAME (Type) George H. Greidinger		23D. ADDRESS U.S.P.H.S. Hosp Balt Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/12/67		24C. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL Cem.		24D. LOCATION BALTIMORE Md.		(State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR John S. MacFarlane		25C. FUNERAL DIRECTOR John S. MacFarlane		ADDRESS 301 Frederick Rd Balt. 28 Md.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6656		CERTIFICATE OF DEATH		67 6656	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>PORTER, HUGH WELTY</u>			7/10/67 5 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION MEMORIAL HOSPITAL</u>			A. STATE <u>MARYLAND</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
D. STREET ADDRESS (If rural, give location) <u>2106 ST. PAUL STREET</u>			12-06		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SEPARATED</u>	8. DATE OF BIRTH <u>6/9/04</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cream Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Power Company</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		13. FATHER'S NAME <u>WILLIAM PORTER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>191 096125</u>		17. INFORMANT <u>WIFE Marie Porter</u>	
18. <u>493X</u>		CAUSE OF DEATH		ADDRESS <u>GREEN ROAD - 21071 GLYNDON, MARYLAND</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u>		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>July 6</u> 19 <u>67</u> to <u>July 10</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 10</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. H. Oehlert, Jr.</u>				23B. DATE SIGNED <u>7/10/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM H. OEHLERT, JR., M.D.</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/12/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>	
25C. FUNERAL DIRECTOR <u>Philip E. Good</u>		25D. ADDRESS <u>1211 Chesapeake Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6657				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6657	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Schedie ORILLA</u>				2. DATE AND HOUR OF DEATH <u>5:50 AM 7/10/1967</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore Co</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>WHITE MARSH</u> <u>53-00</u>			
D. STREET ADDRESS (If rural, give location) <u>REDLINE ROAD</u>							
5. SEX <u>F</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4-26-89</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM KNIGHT</u>				14. MOTHER'S MAIDEN NAME <u>ADA MORRIS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Mrs Viola Schultz Red Lion Road White Marsh</u>			
18. <u>331X1Y-260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>Cerebrovascular Accident</u> (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u> <u>DIABETES Mellitus</u>							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No.</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(I)</u> this hospital attended the deceased from <u>6/24/67</u> 19 to <u>7/10/67</u> 19, that <u>(I)</u> last saw the deceased alive on <u>7/10/67</u> 19 and that in <u>(my)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> <u>(We)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>R. E. Smith</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/10/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>RONALD E. SMITH</u>				23D. ADDRESS M.D. <u>JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-14-1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Camp Chapel Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Loggins Funeral Home 7401 Belair Road</u>			

No.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6658**BIRTH NO. **67 6658**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)**LEO HILLERS**

2. DATE AND HOUR PRONOUNCED DEAD

7-5-67**5:54**

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**301 S. DALLAS COURT - Amb. Crew #10**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

301 S. Dallas

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**Single**

8. DATE OF BIRTH

Jan 7, 19139. AGE (In years
last birthday)**54**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Musician**

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Allentown, Pa.12. CITIZEN OF
WHAT COUNTRY?**U.S.A.**

13. FATHER'S NAME

Leo Hillers Sr.

14. MOTHER'S MAIDEN NAME

Anna Pfeiffer15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)**No**16. SOCIAL
SECURITY NO.**216-05-7908**

17. INFORMANT

ADDRESS

Florence C. Cain-3420 Ravenwood Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) **Arteriosclerotic heart disease**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO(C)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?**Yes**21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

CHARLES S. SPRINGATE, M.D.CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-6-6723A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

7-8-67

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

John C. Miller Inc-6415 Belair Rd.-21206

WILLIAM B. FORD

67 6659

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6659

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROSELLA

PEARSON

2. DATE AND HOUR PRONOUNCED DEAD

June 26, 1967

11:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2016 St. Paul Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2016 St. Paul Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Sept. 2, 1906

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Cincinnati, Ohio

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Gittel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

UNKNOWN

17. INFORMANT

Mr. Harold Posner, 127 E. North Avenue #2

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

No

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/26/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/11/67

23C. NAME of CEMETERY or CREMATORY

Oheb Shalom

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1967

24B. NAME OF REGISTRAR

Robert E. Faldut

24C. FUNERAL DIRECTOR

Spl Levinson & Bros. Inc. 6010 Reist., Rd.

ADDRESS

1000 10

1000 10

1000 10

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6660	
67 6660				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
HERBERT L. LEWIS			JULY 9, 1967 12:15 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL			A. STATE MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 4238 LABYRINTH ROAD #15		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH MAY 21, 1908	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY SHOES	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME SAMUEL LEWIS			14. MOTHER'S MAIDEN NAME ESTHER CARP		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-8211	17. INFORMANT MRS. BEATRICE LEWIS, 4238 LABYRINTH ROAD #15		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <i>Acute Myocardial Infarction and Acute Pulmonary Embolism</i> (B) DUE TO <i>Atherosclerotic Cardiovascular Disease</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-9-67 to 7-9-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph Deckelbaum</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-10-67
23C. PHYSICIAN'S NAME (Type) DR. JOSEPH DECKELBAUM			23D. ADDRESS 3502 W. ROGERS AVENUE		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/10/67		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967			
25B. NAME OF REGISTRAR <i>Paul E. Sullivan</i>		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.			

[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side. Some faint words like "DATE" and "TIME" are visible.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6661	
67 6661				CERTIFICATE OF DEATH	
BIRTH NO. U-1340		M.E. CASE NO.		2. DATE AND HOUR OF DEATH July 8, 1967 1:15 P.M.	
1. NAME OF DECEASED (Type or Print) ROSE UDEL					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (When deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GENERAL HOSP.		A. STATE Maryland			
(If not in hospital or institution, give street address or location) 28th & N. CHARLES STREETS, BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 13-01			
5. SEX F		6. RACE W		D. STREET ADDRESS (If rural, give location) Temple Garden Apt.	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 8/10/1901		9. AGE (In years last birthday) 65 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE AT HOME		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AARON COHEN		14. MOTHER'S M maiden name MINNA HARTZ			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-18-5206		17. INFORMANT chant (MRS. WITTIE SHAPIRO)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RT CEREBRAL THROMBOSIS		CAUSE OF DEATH SISTER			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2-		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 21 1967 to July 8 1967 , that (I) (we) last saw the deceased alive on July 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Fuerman / [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 8, 1967	
23C. PHYSICIAN'S NAME (Type) HARVEY FUERMAN, M.D.		23D. ADDRESS 6210 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 7/10/67		24C. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.	

NORTH CAROLINA DEPARTMENT OF HEALTH
 500 E. W. CHARLES STREET
 WILMINGTON, N. C. 28401
 DECEASED: Margaret
 DATE OF DEATH: July 1, 1968
 PLACE OF DEATH: Home
 CAUSE OF DEATH: Heart Disease
 SIGNATURE OF PHYSICIAN: [Signature]
 SIGNATURE OF DEATH REGISTRAR: [Signature]

215-18-2000 chart (Mrs. WITTE)
 215-18-2000

Dr. Freeman / M.D.
 Attorney Freeman, M.D.
 July 1, 1968
 July 1, 1968

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6662	
BIRTH NO. 67 6662		CERTIFICATE OF DEATH		Registered No. 67 6662	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John W Fuller		2. DATE AND HOUR OF DEATH 7-10-67 9:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY Baltimore Co.		5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - Dundalk 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 49 NORTH Charles Hospital		6. STREET ADDRESS (If rural, give location) 7562 New Battle Grove Rd-21222		7. DATE OF BIRTH 7-7-1895	
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	
8. AGE (In years last birthday) 72		9. Under 1 Yr. Months Days		10. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boiler Eng. Beth. Steel Co.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ALABAMA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Fuller		14. MOTHER'S MAIDEN NAME Ellen Allen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI Army		16. SOCIAL SECURITY NO. 213-09-1580		17. INFORMANT 7562 New Battle Grove Rd. ANNA M. Fuller (wife) Dundalk, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Multiple Myeloma		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 7-3-67	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-3-1967 to 7-10-1967, that (I) (we) last saw the deceased alive on 7-10-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE L. Reigel		23B. DATE SIGNED 7-10-67	
23C. PHYSICIAN'S NAME (Type) MARCOS LEVIN		23D. ADDRESS North Charles General Hospital, Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/67		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Robert E. Farberman	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.					

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67 6663

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6663

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARY

JANE

FRIGUGLIETTI

2. DATE AND HOUR PRONOUNCED DEAD

July 10, 1967

5:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Pennsylvania

B. COUNTY Fayette

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Connellsville

D. STREET ADDRESS (If rural, give location)

901 Roy Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

12/23/59

9. AGE (In years
last birthday)

7

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Prosper Friguglietti

14. MOTHER'S MAIDEN NAME

Rita Haines

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
None17. INFORMANT
(Father)

ADDRESS

Connellsville, Pa. 15425

Mr. Prosper Friguglietti, 901 Roy St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Drowning

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

water

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Beach at end of Millers Island Road

21D. TIME OF INJURY
(APPROX.) July 10, 1967 4:37 P. M.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK21F. HOW DID INJURY OCCUR? Unknown - either went
into deep water or stepped into hole.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/14/67

23C. NAME OF CEMETERY or CREMATORY

St. Rita's Cemetery

23D. LOCATION (City, town, or county)

Connellsville, Pennsylvania

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1967

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

X



67 6664

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6664

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GINA LOUISE

FRIGUGLIETTI

2. DATE AND HOUR PRONOUNCED DEAD

July 10, 1967

5:15 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Pennsylvania

B. COUNTY

Fayette

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Connellsville

D. STREET ADDRESS (If rural, give location)

901 Roy Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

1/10/57

9. AGE (In years
(last birthday))

10

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Prosper Friguglietti

14. MOTHER'S MAIDEN NAME

Rita Haines

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

(Father)

Connellsville, Pa. 15425

Mr. Prosper Friguglietti, 901 Roy St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Drowning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

water

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Beach at end of Millers Island Road

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
July 10, 1967 4:37

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Unknown - either went
into deep water or stepped into hole.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

7/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/14/67

23C. NAME of CEMETERY or CREMATORY

St. Rita's Cemetery

23D. LOCATION

(City, town, or county)

(State)

Connellsville, Pennsylvania

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1967

24B. NAME OF REGISTRAR

Robert E. Fajk, M.D.

24C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 6665		67 6665	
M.E. CASE NO.		Mota C. Rausch		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		RAUSCH, META C.		JULY 11, 1967 12:35AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND Baltimore			
CHURCH HOME AND HOSPITAL 100 NORTH BROADWAY BALTIMORE, MARYLAND 21231		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - Dundalk 53-00			
D. STREET ADDRESS (If rural, give location)		1927 GUYWAY			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
FEMALE	WHITE	Divorced	MARCH 31, 1889	78	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOMEMAKER				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry Juister HENRY JUISTER		JOHANNA FLOCKHORN		AMERICA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) ADDRESS	
NO		217-48-2262		Mrs. Helen Griffith, 1927 Guyway, Dundalk, Md.	
18. 4-20-11		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) CORONARY THROMBOSIS DUE TO			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) GENERALIZED ARTERIOSCLEROSIS DUE TO			
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 29 1967 to JULY 11 1967, that (I) (we) last saw the deceased alive on 7-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE			
Jose Y. Ortiz		M.D.		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		7-11-67	
JOSE Y. ORTIZ		M.D. CHURCH HOME & HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/14/67		Moreland Memorial Park Cem.	
24D. LOCATION (City, town, or county) (State)		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 12 1967		Robert E. Jackson		John J. Duda, 7922 Wise Ave. Dundalk, Md.	

ONLY 11/11/11

WETA

MARYLAND

BALTIMORE

1934 GUYANA

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BALTIMORE, MARYLAND 2131
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GREEN HOME AND HOSPITAL

White Virginia

MARYLAND

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JOHANN 1934

HOMER

HENRY GUSTER

NO

CORONARY THROMBOSIS

GENERALIZED ARTERIOSCLEROSIS

1934 11 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-12492		67. 6666		BALTIMORE CITY HEALTH DEPT CERTIFICATE OF DEATH		Registered No. 67 6666	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY GIRL McLENDON				6/29/67 9:19 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL				A. STATE MD B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 2848 E Federal St.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/29/67	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES McLENDON				14. MOTHER'S MAIDEN NAME Ruby Gillard			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) IMMATUREITY				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 hrs 19 mins	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/29/67 3:00 AM to 6/29/67 9:19 AM , that (I) (we) lost saw the deceased alive on 6/29/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE F. S. PEROMA				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/29/67	
23C. PHYSICIAN'S NAME (Type) F. S. PEROMA		23D. ADDRESS LUTHERAN HOSPITAL BOARD OF MARYLAND					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-10-67		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or County) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6667		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6667	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) WATSON MYRTLE S				July - 10 - 1967 8:20 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY BALTO.	
5. SEX F		6. RACE Cau.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W		8. DATE OF BIRTH 5-22-04		9. AGE (In years last birthday) 63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice-Principal		10B. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) BALTO. Co.	
13. FATHER'S NAME WILLIAM STANSBURY				12. CITIZEN OF WHAT COUNTRY? YES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-38-5609	
17. INFORMANT Mrs. Louise W. Anthony, Baltimore, Maryland				ADDRESS 6012 Bellona Ave.	
18. 476X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Constrictive heart failure DUE TO (B) Rheumatic and hypertensive cardiovascular disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/30/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Embolus. of femoral artery.		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from June - 30 1967 to July - 10 1967 , that (I) (we) last saw the deceased alive on 8:20 pm July - 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dong Sup Cha				23B. DATE SIGNED July - 10 - 1967	
23C. PHYSICIAN'S NAME (Type) DONG SUP CHA				23D. ADDRESS BON SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 13, 67		24C. NAME OF CEMETERY or CREMATORY Chestnut Grove Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Wm. Cook-Brooks			
25D. ADDRESS Towson, Md. 21204					

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 1D-515 67 6668				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6668	
1. NAME OF DECEASED (Type or Print) DANOVAN, Mary (MARY DANOVAN)				2. DATE AND HOUR OF DEATH 7-10-67 3 11 45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL D. STREET ADDRESS (If rural, give location) 2519 Wagner Avenue 21219 53-00			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 7-12-1942	9. AGE (In years last birthday) 24	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Claude Kirby Rose			14. MOTHER'S MAIDEN NAME Margaret Hall				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?????			16. SOCIAL SECURITY NO. ??		17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224		
18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Respiratory Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Keto Acidosis & pneumonia Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 7-8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 0		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work <input checked="" type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 0			
22. I certify that (1) (this hospital) attended the deceased from 7-9 19 67 to 7-10 19 67 , that (1) (we) last saw the deceased alive on 7-10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE P. Desmond				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-10-67	
23C. PHYSICIAN'S NAME (Type) Patrick Desmond				23D. ADDRESS M.D. Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 13, 67		24C. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		24D. LOCATION (City, town, or county) (State) Gordonville, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6669	
BIRTH NO. 67-14087		67 6669		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Girl Roop		2. DATE AND HOUR OF DEATH 7-9-67 12:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		A. STATE B. COUNTY TAPAZ			
44		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md 53-60			
D. STREET ADDRESS (If rural, give location)					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) N M	8. DATE OF BIRTH 7-8-67	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 8 45
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME John Roop		12. CITIZEN OF WHAT COUNTRY USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 776X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Primitively			
ANTECEDENT CAUSES		(B) DUE TO Preterm labor delivery			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 Nov		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) V	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) M		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-8-67 19 to 7-9-67 19, that (I) (we) last saw the deceased alive on 7-9-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hector L. Rodriguez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-9-67	
23C. PHYSICIAN'S NAME (Type) Hector L. Rodriguez		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) 7-10-67		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-11716 67 6670		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6670	
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY BOY BIRDSONG		2. DATE AND HOUR OF DEATH 6/23/67 5:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 425 SINAI Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-11		
			D. STREET ADDRESS (If rural, give location) 3923 Wabash Ave		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/17/67	9. AGE (In years last birthday) 5 18	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME JAMES BIRDSONG			14. MOTHER'S MAIDEN NAME Eloise ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 756.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ascites, pleur pleurisy, respiratory compromise, chemical peritonitis			CAUSE OF DEATH (A) DUE TO Ileal atresia (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/18 + 6/21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED shelation & ① inguinal hernia		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/17/67 to 6/23/67 , that (1) (we) last saw the deceased alive on 6/23/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd I. Kramer M.D.				23B. DATE SIGNED 6/23/67	
23C. PHYSICIAN'S NAME (Type) Lloyd I. KRAMER M.D.				23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-10-67		24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR R. E. Farley, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6671					Registered No. 67 6671				
BIRTH NO. 67-12911					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) MILLER, Baby Boy					2. DATE AND HOUR OF DEATH 7/5/67 4:30/A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI Hosp. OF BALTIMORE, INC.					4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY Cockeysville Md Belts. Co.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE St. Daniel Court 53-00				
					D. STREET ADDRESS (If rural, give location) SINAI Hosp. of Baltimore				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 7/4/67	9. AGE (In years lost birthday) 1 DAY	10. UNDER 1 Yr. Months: Days: Hours: Min. 1 4		11. BIRTHPLACE (State or foreign country) MARYLAND		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ADAMS, DELMAR					14. MOTHER'S MAIDEN NAME BURKE, DOLORES				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT THOMAS P. SMITH M.D.			ADDRESS SINAI Hosp.	
18. CAUSE OF DEATH 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) IMMATURITY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH 1 DAY				
19A. DATE OF OPERATION 2 NONE			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 7/4 19 67 to 7/5 19 67 , that (I) (we) last saw the deceased alive on 7/5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Thomas P. Smith M.D.					23B. DATE SIGNED 7/5/67				
23C. PHYSICIAN'S NAME (Type) Thomas P. Smith					23D. ADDRESS SINAI Hospital of Baltimore, Inc.				
24A. BURIAL CREMATION, REMOVAL (Specify) 7-10-67			24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS		

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67-09689 67 6672					REGISTERED NO. 67 6672				
M.E. CASE NO.					DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>Garther Baby Boy "B"</u>					2. DATE AND HOUR OF DEATH <u>May 17, 1967 6:21 P.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital of Baltimore</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21225 25-32</u>				
D. STREET ADDRESS (If rural, give location) <u>2378 Seamon Ave.</u>									
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u>	8. DATE OF BIRTH <u>5/10/67</u>	9. AGE (In years lost birthday) <u>7</u>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Garther</u>					14. MOTHER'S MAIDEN NAME <u>Patricia Pinkney</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
18. <u>776X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Immaturity</u>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>✓</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> 19 <u>67</u> to <u>5/17</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/17</u> 19 <u>67</u> and that (n) (my), (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Alan J. Manfred</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>5/17/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alan J. Manfred</u> M.D.					23D. ADDRESS <u>Sinai Hospital of Baltimore</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>7-1067</u>			24B. DATE			24C. NAME OF CEMETERY OR CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>			25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>			

1933 - 1934 - 1935 - 1936 - 1937 - 1938 - 1939 - 1940 - 1941 - 1942 - 1943 - 1944 - 1945 - 1946 - 1947 - 1948 - 1949 - 1950 - 1951 - 1952 - 1953 - 1954 - 1955 - 1956 - 1957 - 1958 - 1959 - 1960 - 1961 - 1962 - 1963 - 1964 - 1965 - 1966 - 1967 - 1968 - 1969 - 1970 - 1971 - 1972 - 1973 - 1974 - 1975 - 1976 - 1977 - 1978 - 1979 - 1980 - 1981 - 1982 - 1983 - 1984 - 1985 - 1986 - 1987 - 1988 - 1989 - 1990 - 1991 - 1992 - 1993 - 1994 - 1995 - 1996 - 1997 - 1998 - 1999 - 2000 - 2001 - 2002 - 2003 - 2004 - 2005 - 2006 - 2007 - 2008 - 2009 - 2010 - 2011 - 2012 - 2013 - 2014 - 2015 - 2016 - 2017 - 2018 - 2019 - 2020 - 2021 - 2022 - 2023 - 2024 - 2025

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-09484		67 6673		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6673	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) GA, then Twin A			
2. DATE AND HOUR OF DEATH 5-11-67 5:45 A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) H2 Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY			
5. SEX M				6. RACE N			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH 5-10-67			
9. AGE (In years last birthday) 16				10. CITIZEN OF WHAT COUNTRY? 07			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Gaither				14. MOTHER'S MAIDEN NAME Pinkney			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				ADDRESS			
18. 776X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Prematurity				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 5-10-67 to 5-11-67, that (I) (we) lost saw the deceased alive on 5-11-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stephen Gordon				23B. DATE SIGNED 5-11-67			
23C. PHYSICIAN'S NAME (Type) Stephen Gordon				23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) 7-10-67				24C. NAME OF CEMETERY OR CREMATORY ANATOLIAN CEMETERY			
24B. DATE 7-10-67				24D. LOCATION (City, town, & county) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967				25B. NAME OF REGISTRAR Robert E. Taylor			
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD				25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6674	
BIRTH NO. 67-12231 67 6674				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby girl Wiggins - father			2. DATE AND HOUR OF DEATH 6/25/67 10 ⁰⁵ _{PM}		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-38 D. STREET ADDRESS (If rural, give location) 3631 Liberty Heights AVE.		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 432 S. Lincoln Hospital					
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/24/67	9. AGE (In years lost birthday) 80 days	10. Under 1 Yr. Months: Days: Hours: Min. 1 7 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME CATHERINE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Immaturity			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ✓	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/24/67 19 67 to 6/25/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 6/25/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-10-67		24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR JUL 12 1967		25C. FUNERAL DIRECTOR ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-12929</u> <u>67</u> <u>6675</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67</u> <u>6675</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby Boy Sydnor</u>		2. DATE AND HOUR OF DEATH <u>June 18-67</u> <u>11 35 PM</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY _____		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>27-16</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>425 SINAI HOSP.</u>		D. STREET ADDRESS (If rural, give location) <u>4702 Delaware Ave</u>		E. DATE OF BIRTH <u>6/18/67</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never</u>	9. AGE (In years last birthday) <u>48 MIN.</u>	10. If Under 1 Yr. Months: Days: Hours: _____	11. If Under 24 Hrs. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Sinai Hosp.</u>	
13. FATHER'S NAME <u>John Sydnor</u>		14. MOTHER'S MAIDEN NAME <u>EVA CRAIG</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>762.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>INTRAUTERINE ANOXIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>PREMATURE</u> (B) DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>✓</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 18 1967</u> to <u>June 18 1967</u> , that (I) (we) last saw the deceased alive on <u>June 18 1967</u> and that (in my) (your) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lloyd Kramer</u> M.D.				23B. DATE SIGNED <u>June 18, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>LLOYD KRAMER</u> M.D.				23D. ADDRESS <u>SINAI HOSP.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7-10-67</u>		24C. NAME of CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farnham</u>		25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u>	
MORTUARY SERVICE - BCHD					

67-0850

67-0850

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-13551</u> <u>67 6676</u>		CITY OF BALTIMORE		DEATH CERTIFICATE		Registered No. <u>67 6676</u>	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Baby boy Schon</u>				5 ³⁵ / _P , 7-5-67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp</u>				A. STATE <u>Balto. Co.</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				<u>1924 E. Tappa Rd. Balto. 4 Md.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>7-5-67</u>	9. AGE (In years last birthday) <u>1 day</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	<u>5 min</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>				<u>Maryland</u>		<u>American</u>	
13. FATHER'S NAME <u>Herbert J. Schon</u>				14. MOTHER'S MAIDEN NAME <u>Ludia Esther Deynes</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mother</u>	
18. <u>771.0 I</u>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <u>Neonatal Respiratory distress</u>			
ANTECEDENT CAUSES				(B) <u>possible hemorrhagic disorders</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Resp. distress & aspiration</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-5</u> 19 <u>67</u> to <u>7-5</u> 19 <u>67</u> . that (I) (we) last saw the deceased alive on <u>7-5</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Li-tong Chul Yoon</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-5-67</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7-10-67</u>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>6226 E. Fairview</u>		25C. FUNERAL DIRECTOR		ADDRESS	

for the water & water

1-2 1-2 1-2 1-2

1-2 1-2 1-2 1-2

FUNERAL DIRECTOR: IMPORTANT

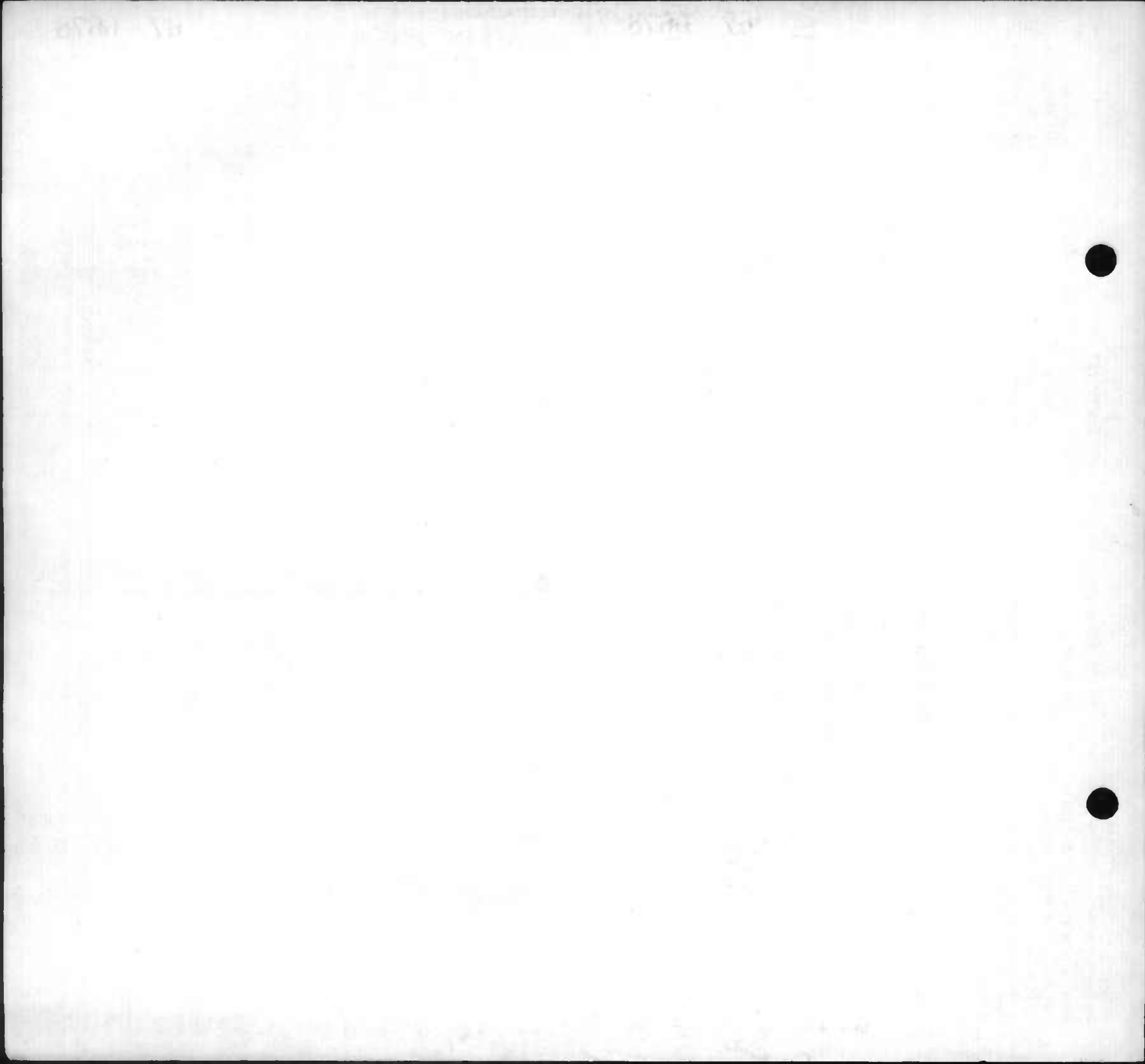
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6677	
BIRTH NO. 07-12954 67 6677		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) 84yr GIRL SNYDER		2. DATE AND HOUR OF DEATH 7/5/67 2:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION H6 LUTHERAN HOSPITAL		A. STATE MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 21 S. ROBINSON ST. 1-02			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 7-5-67	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min. 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME HARRY SNYDER		14. MOTHER'S MAIDEN NAME Nancy Pritchett		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 720.01		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Cryptosporidiosis		3 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3 7/5/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cryptosporidiosis		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5/67 19 to 7/5-67 19, that (I) (we) last saw the deceased alive on 7/5/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Gheranna				23B. DATE SIGNED 7/5/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D. ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-10-67		24C. NAME OF CEMETERY or CREMATORY	
				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 12 1967		Robert E. Farber		MORTUARY SERVICE - BCHD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-19581</u>		67. 6678		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 6678</u>	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Newman</u>				July 6, 1967 6:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Md. GEN. Hosp.</u>				A. STATE <u>md</u> B. COUNTY <u>12-03</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>2418 N. Calvert St</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NB</u>	8. DATE OF BIRTH <u>7/6/67</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>U.S.A. - md</u>		<u>USA</u>	
13. FATHER'S NAME <u>James Edward Boone</u>				14. MOTHER'S MAIDEN NAME <u>Annie Louise Newman</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						<u>mother</u> <u>Same</u>	
18. <u>773.81</u>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) <u>RESPIRATORY FAILURE</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B) <u>PREMATURITY</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>0</u>				<u>✓</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>July 6 1967</u> to <u>July 6 1967</u> , that (I) (we) last saw the deceased alive on <u>July 6 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/6/67</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>827 E. Underwood Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)	
<u>Removal</u>		<u>7-10-67</u>		<u>ANATOMIC BOARD OF MARYLAND</u>		<u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<u>JUL 12 1967</u>		<u>Robert E. Taylor, MD</u>		<u>[Signature]</u>		<u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6679	
BIRTH NO. 07-13485 67 6679		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		POWERS, BABY BOY		7-9-67 10:35 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL		MARYLAND			
33		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		7-05	
		D. STREET ADDRESS (If rural, give location)			
		825 NORTH CAROLINE STREET			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	NEGRO	NEVER MARRIED	7-9-67	3 25	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
		MADELINE POWERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 762.51		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) ASPHYXIA NEONATORUM		3 HR 25 MIN	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) PRIMARY APNEA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C) PREMATURITY			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-9-67 19 to 7-9-67 19, that (I) (we) lost saw the deceased alive on 7-9-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
ARTHUR L. BEAUDET				7-9-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ARTHUR L. BEAUDET				JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
CREMATION		7-10-67		JOHNS HOPKINS HOSPITAL	
				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 12 1967		R. E. F. F. F.		HOSPITAL DISPOSAL	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VERNON

DARGAN

2. DATE AND HOUR PRONOUNCED DEAD

July 11, 1967

3:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2611 Spellman Road (DOA)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2611 Spellman Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-23-29

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Ruffus Dargan

14. MOTHER'S MAIDEN NAME

Mary Daniels

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

220246248

17. INFORMANT

ADDRESS

Gladys Dargan 2611 Spellman Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Purulent Peritonitis

DUE TO

perforation of duodenal peptic
ulcer

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Partial

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-15-67

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

23D. LOCATION

(City, town, or county)

Arbutus

Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 12 1967

Kelson Funeral Home 1348 Calhoun St.

1
S-353

67 6681

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6681

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GARY STANTON

2. DATE AND HOUR PRONOUNCED DEAD

July 10, 1967

9:40 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION

8-8-67

92 Baltimore City Jail

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2234 Etting Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

1-9-44

9. AGE (In years
last birthday)

-24 23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Corenthian Stanton

14. MOTHER'S MAIDEN NAME

Roseella Biggers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
219387326

17. INFORMANT

ADDRESS

Rosella Stanton 2215 Etting Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty metamorphosis of liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER

M.D.

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

DATE SIGNED

July 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-13-67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1967

24B. NAME OF REGISTRAR

Charles E. Jackson

24C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

ADDRESS

V.S. 153 and Birth Cert. F-92553 - 1944
8-8-67 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6682</u>	
BIRTH NO. <u>67 6682</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Arthur Powell</u>			
2. DATE AND HOUR OF DEATH <u>July 9, 1967</u>		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 4005 Forest Park Avenue</u>		A. STATE <u>Md.</u> B. COUNTY			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u>		D. STREET ADDRESS (If rural, give location) <u>4005 Forest Park Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>Negroid</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>12-3-17</u>	9. AGE (In years last birthday) <u>49</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Andrew Powell</u>			
14. MOTHER'S MAIDEN NAME <u>Bertha Woods</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>215014430</u>		17. INFORMANT ADDRESS <u>Coletta Powell 4005 Forest Park Ave.</u>			
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Coronary Thrombosis</u> DUE TO (B) <u>Diabetes Mellitus & Uncontrolled Blood Sugar</u> DUE TO (C) <u>18 months +</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7-9-67</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-16-67</u> 19 <u>67</u> to <u>6-20-67</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-20-67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>I. Bradshaw Higgins</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7-10-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>I. Bradshaw Higgins</u>		23D. ADDRESS <u>2243 Madison Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Kelson Funeral Home 1348 Calhoun St.</u>			

WATERBURY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-13917 67. 6683				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6683	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY Boy Cadden				2. DATE AND HOUR OF DEATH JUNE 25, 1967 10⁴² P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Ind GEN Hosp.		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21230			
				D. STREET ADDRESS (If rural, give location) 1719 BELT ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NS	8. DATE OF BIRTH JUNE 25, 1967	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Alfred Hillary Cadden				14. MOTHER'S MAIDEN NAME Linda May Slick			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother	
18. 761.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(A) MARGINAL SEPARATION OF PLACENTA.							
(B) INMATUREITY.							
(C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NO.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 25 1967 to JUNE 25 1967 , that (I) (we) lost saw the deceased alive on JUNE 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Carlos E. Arrabal				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-27-67.	
23C. PHYSICIAN'S NAME (Type) CARLOS E ARRABAL				23D. ADDRESS 2705 MOUNTAIN RD - PASADENA MD 21123			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-7-67		24C. NAME OF CEMETERY or CREMATORY ANATOLIAN CEMETERY			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Charles E. Fickens		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD			

RECEIVED - 2000
NEW YORK

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67. 6684

BALTIMORE CITY HEALTH DEPARTMENT

67. 6684

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

STEVEN

A.

BOONE

2. DATE AND HOUR PRONOUNCED DEAD

July 10, 1967

1:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44
99
Union Memorial Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1701 Hope Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Aug. 26, 1952

9. AGE (In years
last birthday)

14

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Boone

14. MOTHER'S MAIDEN NAME

Mattie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mattie Davis 1701 N. Hope Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Multiple Injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Curtain & Aisquith Sts.

21D. TIME
OF INJURY
(APPROX.)

7/10/67

1:25 p.m.

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subj. operating
bicycle - struck by car

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion

resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/14/67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel Cty., Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1967

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Wm C March

ADDRESS

928 E. North Ave.

1888 10 10

1888 10 10

1888 10 10

67 6685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 6685

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Boone Lewis

2. DATE AND HOUR OF DEATH

7-5-67 8:33/P.M.

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
(INSTITUTION)(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

433 W. BIDDLE STREET #21201

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

3-25-00

9. AGE (In years
lost birthday)

67

If Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ACTION BOONE

14. MOTHER'S MAIDEN NAME

BETSY

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

244-16-5492A

17. INFORMANT

ADDRESS

MD.

RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224,

18. *161X*DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) *Probable aspiration of
foreign material.*(B) *CA of injury*

(C)

INTERVAL BETWEEN
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.*none*

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

10/13/66

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED*Thyroidectomy*

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)*None*21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

—

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-9 1966 to 7-5 1967,
that (I) (we) last saw the deceased alive on 7-5 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Patrick Desmond

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7-5-67

23C. PHYSICIAN'S
NAME (Type)

DR. PATRICK DESMOND

23D. ADDRESS

M.D.

BALTIMORE CITY HOSPITALS, 4940 EASTERN AVE.

BALTIMORE 21224, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/11/67

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

24D. LOCATION

(City, town, or county)

A A County Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 12 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6686		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66-35	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Sylvester Talley		2. DATE AND HOUR OF DEATH 7/8/67 1:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Dukeland Convalescent Nursing Home, 1501 N. Dukeland Street, Baltimore, Maryland 21216		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Carroll C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Maryland D. STREET ADDRESS (If rural, give location) 24 S. CARROLLTON AVE/803			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) X	8. DATE OF BIRTH 3-20-02	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) X		10B. KIND OF BUSINESS OR INDUSTRY X		11. BIRTHPLACE (State or foreign country) X	
12. CITIZEN OF WHAT COUNTRY? U. States		13. FATHER'S NAME X		14. MOTHER'S MAIDEN NAME X	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) X		16. SOCIAL SECURITY NO. 228-03-2597		17. INFORMANT Chart,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II		CAUSE OF DEATH (A) DUE TO Hypertensive Cardiovascular Disease (B) DUE TO Unknown (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Unknown	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/16 1966 to 7/8 1967 , that (I) (we) lost saw the deceased alive on 7/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Alay Harris, MD				23B. DATE SIGNED 7/8/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/67		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Adolphus Halstead			
ADDRESS 1206 W North Ave					

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M-626

67 6687

BALTIMORE CITY HEALTH DEPARTMENT

67 6687

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ROLAND MERCER Jr.				2. DATE AND HOUR PRONOUNCED DEAD July 9, 1967 6:05 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Wagner's Point - Curtis Bay				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2102 Elsinore Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH June 24, 1937	9. AGE (In years last birthday) 30	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur			10B. KIND OF BUSINESS OR INDUSTRY Cab Co.		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Roland Mercer Sr.			
14. MOTHER'S MAIDEN NAME Lena Johnson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 217-34-3990				17. INFORMANT ADDRESS Roland Mercer- Sr. 2102 Elsinore Ave.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Drowning ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 7-9-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) water		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Wagner's Point - Curtis Bay			
21D. TIME OF INJURY (APPROX.) 7-9-67 4:50 P.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Row-boat overturned			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 10, 1967							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7/14/67		23C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore Maryland	
24A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave.			

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WALLACE HOLLAND

WALLACE HOLLAND

WALLACE HOLLAND

49-06-16 ED
M-603

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6688		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6688	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Eula Moore</i>		2. DATE AND HOUR OF DEATH <i>7/9/67 8:00 am</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i> <i>4940 Eastern Ave.</i> <i>Baltimore, Maryland # 21224</i>		A. STATE <i>Maryland</i> B. COUNTY <i>16-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, Md 21217</i> D. STREET ADDRESS (If rural, give location) <i>810 McKean Ave.</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widow</i>	8. DATE OF BIRTH <i>8/20/96</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>S. Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Willis Edwards</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Conats</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>220-12-9087A</i>		17. INFORMANT <i>medical history chart</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Septisemia</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>diabetes mellitus.</i> <i>CVA</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 1/2 - 5 days</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>perforated ulcer</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>4/12/1967</i> to <i>7/9/1967</i> , that (1) (we) last saw the deceased alive on <i>7/8</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Francine Siegal</i>				23B. DATE SIGNED <i>7/9/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>FRANCINE SIEGAL</i>				23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Ave. Baltimore, Md. # 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7/12/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MOUNT AUBURN Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>HERBERT E. NUTTER</i>	
				ADDRESS <i>3085 W. North Ave.</i>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6689		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 6689	
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Carrie Cecelia Peters					July 7, 1967 3 PM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
1936, Druid Hill Ave.					Maryland 14-03				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					Baltimore				
D. STREET ADDRESS (If rural, give location)					1936 Druid Hill Ave.				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	
Female	Colored	Single	Oct. 25, 1893	73					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Teacher Ret & Nurse			Public School-Family			Brownsburg Virginia		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Joseph A. Peters					Henrietta Shultz				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			121-22-0887-A		Lloyd Peters- 1936 Druid Hill Ave.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Anterior-sclerotic Hypertensive Cardio-vascular disease				15 yrs		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			abdominal aortic aneurysm. Exogenous obesity						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
1962		aneurysm		NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1952 to 1967, that (I) (we) last saw the deceased alive on 6/29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
RAYNER BROWNE, M. D. 1500 EAST MADISON ST. BALTIMORE, MD. 21205					7-10-67				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY		24D. LOCATION (City, town, or county) (State)			
Burial		7/11/67		Mount Auburn Cemetery		Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS		
JUL 12 1967		Herbert E. Nutter		Herbert E. Nutter			3035 W. North Ave.		

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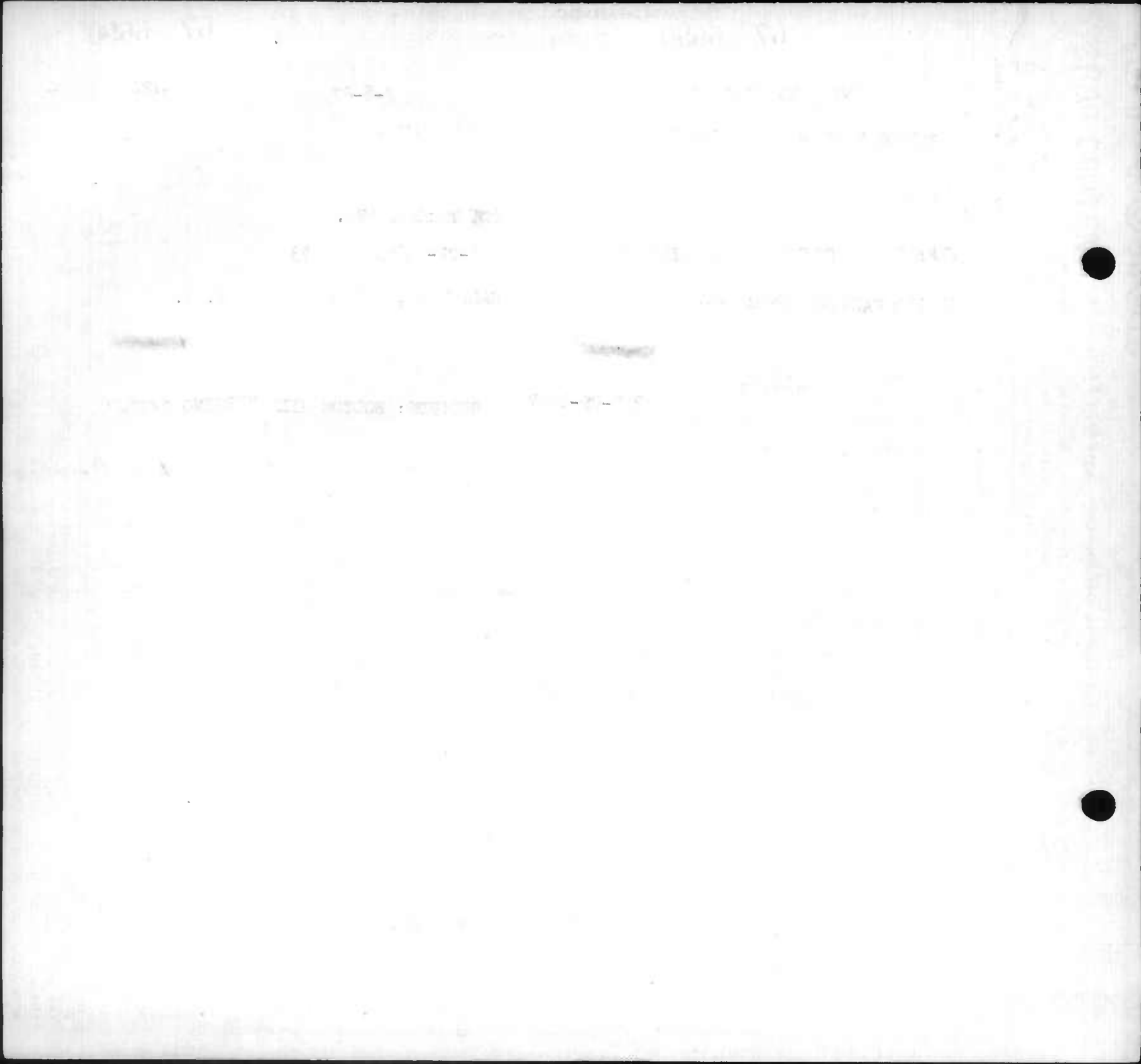
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6690		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6690	
1. NAME OF DECEASED (Type or Print) OVA WASHINGTON			2. DATE AND HOUR OF DEATH 7-8-67 9:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND BOLTON HILL NURSING CENTER (If in hospital, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
5. SEX FEMALE			6. RACE NERGO		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED			8. DATE OF BIRTH II-22-1893		
9. AGE (In years lost birthday) 73			10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME John Webb			14. MOTHER'S MAIDEN NAME Mary Henry		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-09-4147 A		
17. INFORMANT RECORDS: BOLTON HILL NURSING CENTER			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral vascular accident DUE TO to right hemiparesis (B) generalized arteriosclerosis DUE TO years (C) cellulitis of ulcer of leg d) diabetes mellitus years			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/16 1965 to 7/8 1967 , that (I) (we) last saw the deceased alive on 7/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALLAN H. MACHT M.D.				23B. DATE SIGNED 7/8/67	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D.				23D. ADDRESS 2 EAST READ ST 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR Herbert E. Nutter		25C. FUNERAL DIRECTOR ADDRESS 3035 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
67 6691					CERTIFICATE OF DEATH					Registered No. 67 6691									
BIRTH NO.										M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) COOPER CHARLES										2. DATE AND HOUR OF DEATH 7-8-67 12 45 P.M.									
3. PLACE OF DEATH IN BALTIMORE/ MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Maryland										A. STATE Maryland B. COUNTY 16-05									
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Maryland										D. STREET ADDRESS (If rural, give location) 1119 N. Bentalou st,									
5. SEX M		6. RACE C		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 8/28/1894		9. AGE (In years last birthday) 72		11. Under 1 Yr. Months: Days: Hours: Min.		12. Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10B. KIND OF BUSINESS OR INDUSTRY None					11. BIRTHPLACE (State or foreign country) Baltimore Maryland					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Samuel Cooper										14. MOTHER'S MAIDEN NAME Mary Green									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. None					17. INFORMANT ADDRESS Florence Woods-1119 N. Bentalou Street									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) Cancer of Prostate DUE TO										INTERVAL BETWEEN ONSET AND DEATH 5 weeks									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(B) DUE TO									
(C) DUE TO																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 7-13-67					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓					20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input checked="" type="checkbox"/>									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <input checked="" type="checkbox"/>					21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input checked="" type="checkbox"/> Work					21F. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 6-13-1967 to 7-8-1967 , that (I) (we) last saw the deceased alive on 7-8-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Nguyen Thi Oanh M.D.										Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 7-8-67				
23C. PHYSICIAN'S NAME (Type) NGUYEN THI OANH M.D.										23D. ADDRESS Lutheran Hospital of Maryland									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7/12/67					24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore Maryland				
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967					25B. NAME OF REGISTRAR Robert E. Taylor					25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.					ADDRESS				

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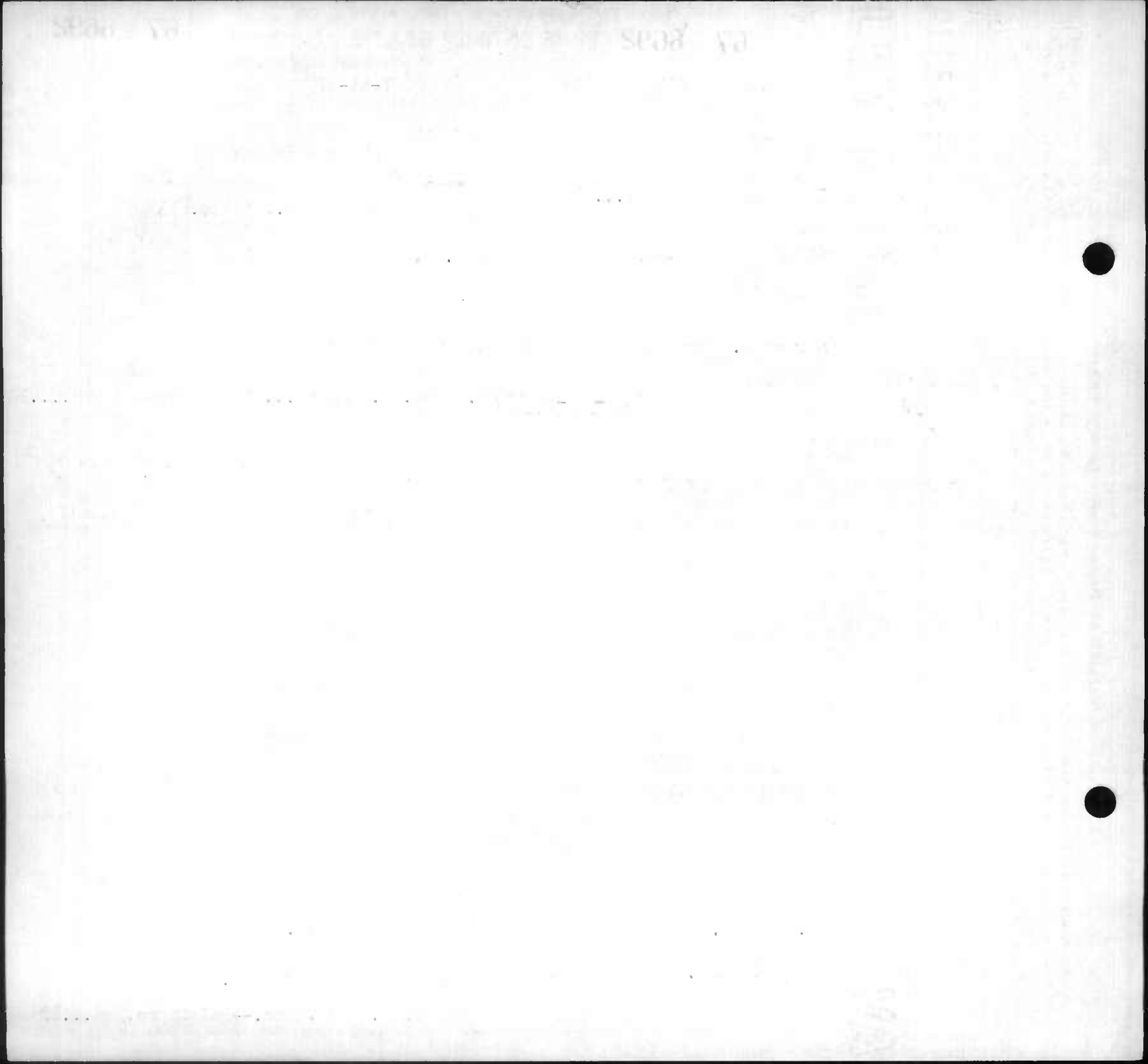
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		67 6692 CERTIFICATE OF DEATH				Registered No.		67 6692	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KATHERINE (KATE) GROGAN				2. DATE AND HOUR OF DEATH 7-11-67 5⁰⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3807 Ravenwood Ave....13					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3807 Ravenwood Ave., Balto. 13				
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH Jan. 1, 1885	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Patrick H. Geraghty					14. MOTHER'S MAIDEN NAME Kate Dougherty				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-54-8952		17. INFORMANT ADDRESS Mr. Thos. P. Grogan...3807 Ravenwood Ave....13				
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. old age.					CAUSE OF DEATH (A) DUE TO Metastatic Carcinoma (B) DUE TO Carcinoma left breast (C)		INTERVAL BETWEEN ONSET AND DEATH 29 months 29 months		
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/13/1965 to 7/11/1967 , that (I) (we) last saw the deceased alive on 5/31/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Paul H. Anniko M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 7/11/67	
23C. PHYSICIAN'S NAME (Type) Dr. Paul H. Anniko M.D.					23D. ADDRESS 3800 Erdman Ave.				
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 7/14/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967			25B. NAME OF REGISTRAR Robert E. Talbot			25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc.--Baltimore, Md...13			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6693	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 6693 CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Kathleen E. Sanks			2. DATE AND HOUR OF DEATH July 11 1967 10:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 2104 Kentucky Ave.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
(If not in hospital or institution, give street address or location)			D. STREET ADDRESS (If rural, give location) 2104 Kentucky Avenue		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Oct. 26, 1905	9. AGE (In years last birthday) 61	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Thomas Donellan		
14. MOTHER'S MAIDEN NAME Catherine O'Hara			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-38-1230			17. INFORMANT Margaret A. Sanks		
ADDRESS (Same)			18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Acute Embolic Stroke			INTERVAL BETWEEN ONSET AND DEATH 1-2 hours		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Vascular Disease			5 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Apathy			75 years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/2/67 to 7/11/67 , that (I) (we) last saw the deceased alive on 7/6/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley			23B. DATE SIGNED 7/11/67		
23C. PHYSICIAN'S NAME (Type) Dr. Albert Bradley			23D. ADDRESS 4900 Belair Rd., Balto. Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/67		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

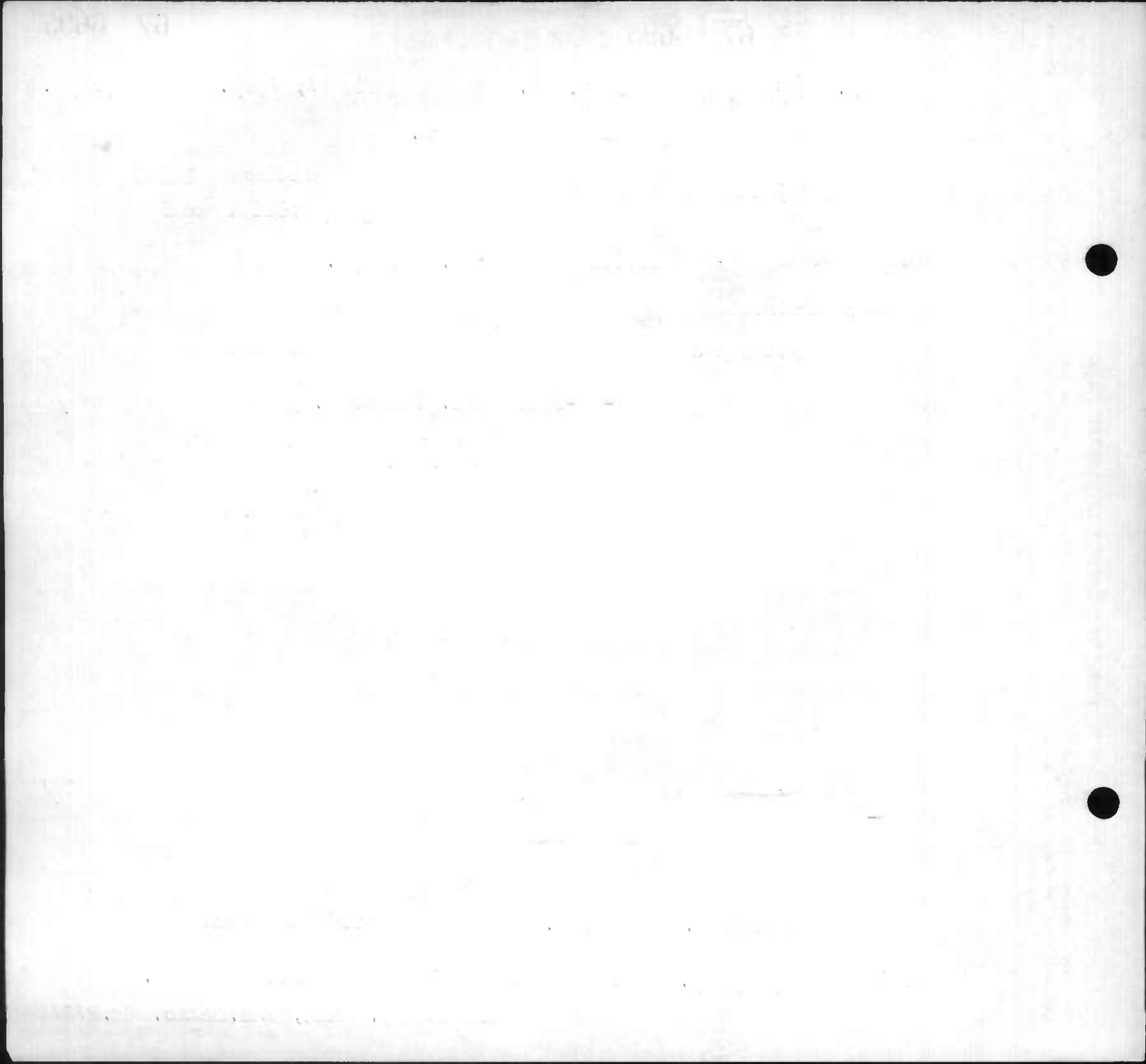
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6694	
BIRTH NO. 67 6694				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) MACDONNELL RUBY L.				2. DATE AND HOUR OF DEATH 7/11/67 2:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL				A. STATE MD. B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.	
				D. STREET ADDRESS (If rural, give location) 1508 PENTRIDGE RD	
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 3/17/89	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Bader			
14. MOTHER'S MAIDEN NAME Milner		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 214-10-6401A		17. INFORMANT Mr. Wilmer E. Bader 2303 Eastridge Rd.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ASYSTOLE				48'	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from July 9 1967 to July 11 1967 , that (I) (we) last saw the deceased alive on July 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Th. Susan Ballinger				23B. DATE SIGNED July 11 1967	
23C. PHYSICIAN'S NAME (Type) —				23D. ADDRESS 2931 Mallon Rd Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			

- - 2

FUNERAL DIRECTOR: IMPORTANT

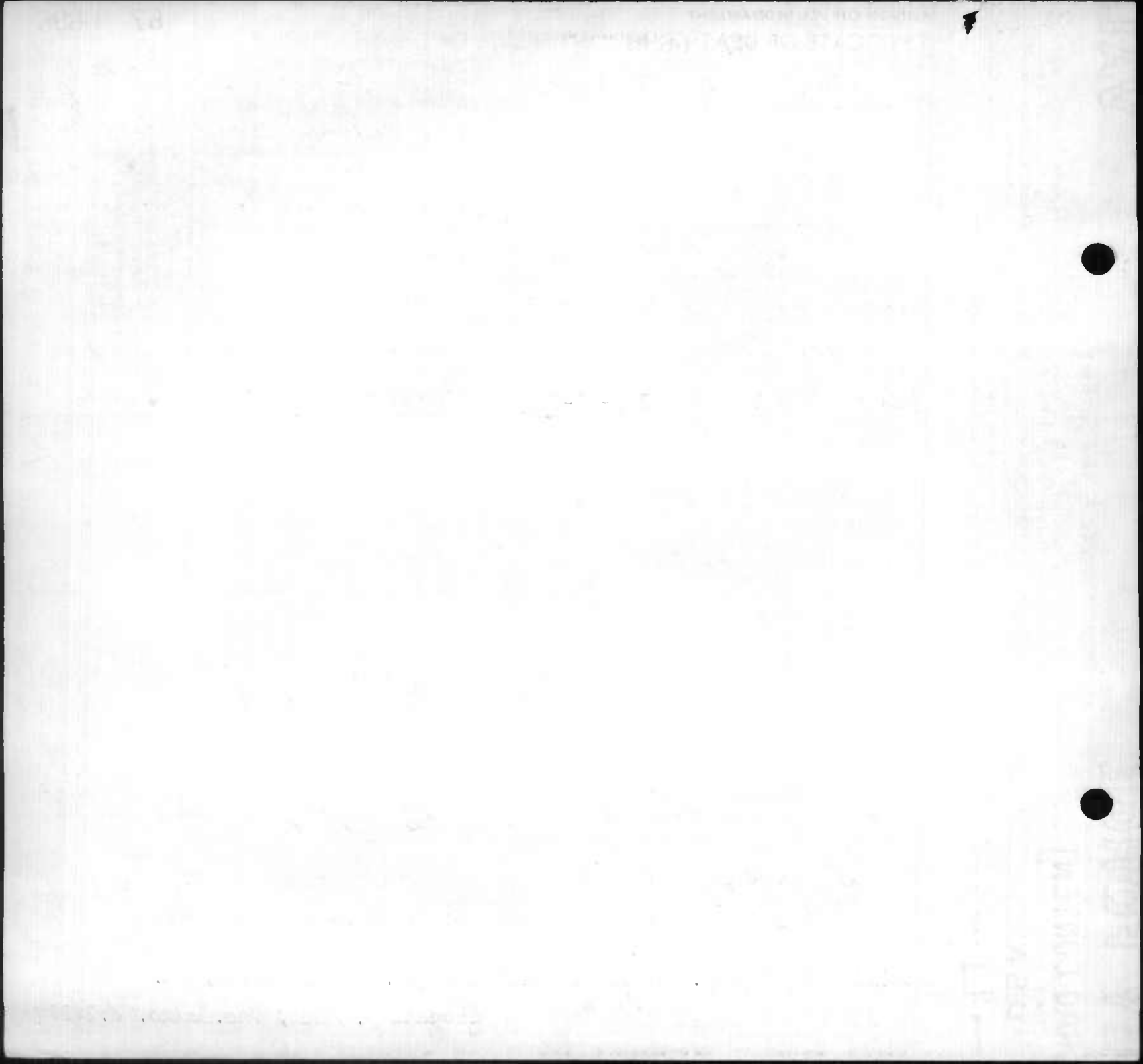
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6695 CERTIFICATE OF DEATH					Registered No. 67 6695				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>E. Guy Gray, Sr.</i>					2. DATE AND HOUR OF DEATH <i>July 11, 1967. 9:45 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 5009 Hillen Road</i>					A. STATE <i>Md.</i> B. COUNTY				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21212 27-09</i>					D. STREET ADDRESS (If rural, give location) <i>5009 Hillen Road</i>				
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 22, 1895.</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Banker</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Harry Gray</i>					14. MOTHER'S MAIDEN NAME <i>Loula Pegg</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>216-03-8080</i>		17. INFORMANT <i>Mrs. Thelma M. Gray</i>		ADDRESS <i>(Same)</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cor Pulmonale with Chronic Decompensation.</i>					INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs.</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Pulmonary Emphysema</i>					12 yrs.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>					7 yrs.				
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>1967</i> to <i>July 1967</i> , that (I) (we) lost saw the deceased alive on <i>July 4</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Wm. H. Kammer, Jr.</i>					M.D. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/12/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>William H. Kammer, Jr.</i>					23D. ADDRESS <i>6001 York Road</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/15/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1967</i>		25B. NAME OF REGISTRAR <i>Leonard J. Ruck, Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Balto. Md. 21214</i>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6696
BIRTH NO. 67 6696		CERTIFICATE OF DEATH		
M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) CHARLES R. TRIMBLE		2. DATE AND HOUR OF DEATH 7-11-67 2¹⁵ P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES HOSP		A. STATE MARYLAND B. COUNTY		
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-01		
		D. STREET ADDRESS (If rural, give location) 5130 CEDONIA AV BALTIMORE		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-22-26	9. AGE (In years last birthday) 40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Drugs. Company	11. BIRTHPLACE (State or foreign country) Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Trimble Pa		14. MOTHER'S MAIDEN NAME Florence Armit Ind.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW2		16. SOCIAL SECURITY NO. 248-32-2045	17. INFORMANT ADDRESS MARGARET TRIMBLE Same.	
18. 237X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BRAIN TUMOR.		INTERVAL BETWEEN ONSET AND DEATH June - 1965		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION June-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR	20A. AUTOPSY? (Yes or No) Yes -	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-July 1967 to 7-11 1967 , that (I) (we) last saw the deceased alive on 7-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE L Ruyel		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 7-11-67	
23C. PHYSICIAN'S NAME (Type) Jury Hinn		23D. ADDRESS M.D. 50002 FRANKFORD AV.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/14/67	24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967	25B. NAME OF REGISTRAR R. E. F. F.	25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6697				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6697	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) CIRELLI ANTHONY M.		2. DATE AND HOUR OF DEATH 7/10/67 6-20 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 35 911 Eastern Ave.							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/14/11	9. AGE (In years last birthday) 56 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY BREWERY.		11. BIRTHPLACE (State or foreign country) BALTO. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES CIRELLI				14. MOTHER'S MAIDEN NAME GENEVIEVE MALTROTTA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES MARINES		16. SOCIAL SECURITY NO. 214-01-7483		17. INFORMANT ADDRESS MRS. ANNA M CIRELLI 911 EASTERN AVE			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension				(A) Respiratory failure due to CVA. DUE TO (B) DUE TO (C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 9, 1967 to July 10, 1967, that (X) (we) last saw the deceased alive on July 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rodelio M. Lim M.D.				23B. DATE SIGNED 7-10-67			
23C. PHYSICIAN'S NAME (Type) Rodelio M. Lim M.D.				23D. ADDRESS CHH			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/14/67		24C. NAME OF CEMETERY or CREMATORY SACRED HEART GERMAN HILL RD. DUNDALK Md.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1967		25B. NAME OF REGISTRAR R. E. Jackson		25C. FUNERAL DIRECTOR L. A. Della Voce		ADDRESS 322 S HIGH ST	

Revised 11/1/11
Kathleen M. Smith

CH

B-650

67 6698

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6698

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOHN

BROWN

2. DATE AND HOUR PRONOUNCED DEAD

July 10, 1967

2:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

915 N. Dallas Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

915 N. Dallas Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

June 17 1907

9. AGE (In years last birthday)

60

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, if not retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Greenville S Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Brown Sr.

14. MOTHER'S MAIDEN NAME

Lillie Paul

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

C. W. Reeder 1334 W. Presumably

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Emphysema DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardiovascular Disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

7/11/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

7-15-67

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION (City, town, or county) (State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1967

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

Shirley Wilson 1000 Brantley Rd

ADDRESS

10

1000 10

1000 10

1000 10

1000 10

1000 10

1000 10

1000 10

67. 6699

BALTIMORE CITY HEALTH DEPARTMENT

67. 6699

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CORA WOODLEY

2. DATE AND HOUR PRONOUNCED DEAD

July 12, 1967 11:15 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1915 W. Fairmount Avenue

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

APRIL 15, 1884

9. AGE (In years
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

PRINCE GEORGE, VA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ARDON JACKSON

14. MOTHER'S MAIDEN NAME

NETTIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MARY JONES 1915 W. FAIRMOUNT AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Buried 7-13-67

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

LITTLE MOUNT BAPT.

23D. LOCATION

(City, town, or county)

(State)

Sussex Co. Va.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 13 1967

R. S. Fisher, M.D.

Marshall P. Hays 638 N. GILMAN ST
Ft. Belvoir, Fort Belvoir, Fort Belvoir, VA

1000

My dear Mr. ...
I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Yours very truly,
J. M. ...

Respectfully,
J. M. ...

49-54-69 GG 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6700				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6700			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) FERGUSON, JOSEPHINE				2. DATE AND HOUR OF DEATH 7/9/67 1:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND				D. STREET ADDRESS (If rural, give location) 1307 S. CLINTON ST. 21224							
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6-11-09.		9. AGE (In years last birthday) 58		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK				10B. KIND OF BUSINESS OR INDUSTRY AT HOME				11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ? DELFONZO				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-03-6846				17. INFORMANT RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224, MD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) C.V.A.				CAUSE OF DEATH (A) C.V.A. DUE TO				INTERVAL BETWEEN ONSET AND DEATH 18 DAYS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) Arteriosclerotic Vascular Disease DUE TO				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Rheumatoid Arthritis Hypertension											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from JUNE 22, 19 67 to July 9, 19 67 , that (I) (we) last saw the deceased alive on July 9, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Benjamin Lechner				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED July 9, 1967			
23C. PHYSICIAN'S NAME (Type) DR. BENJAMIN LECHNER				M.D. 23D. ADDRESS BALTIMORE CITY HOSPITALS				23E. ADDRESS BALTIMORE 21224, MD. 4940 EASTERN AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 7-12-67				24C. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.			
24D. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD. BALTO, CO., MD.				25A. DATE REC'D BY HEALTH DEPT. JUL 13 1967				25B. NAME OF REGISTRAR Robert E. Taylor			
25C. FUNERAL DIRECTOR Charles S. Zeller				25D. ADDRESS 9015 CONKLING ST. BALTO., 21224, MD.							

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67. 6701		CERTIFICATE OF DEATH		67. 6701	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Mr. IRVING E. RUBY</i>			July 9th. 1967 1.05 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i>			A. STATE <i>Md.</i> B. COUNTY <i>Carroll Co.</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Rural - Sykesville</i>		
D. STREET ADDRESS (If rural, give location) <i>44 Pine Knob Rd.</i>					
5. SEX <i>Male</i>	6. RACE <i>W (C)</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>Dec. 3rd. 1899</i>	9. AGE (In years last birthday) <i>87</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>FARMING</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>John Ruby</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>217-36-4137</i>		
17. INFORMANT <i>Mrs. Jennie Ruby - Sykesville, Md.</i>			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Old age</i> <i>acute urinary retention a few months</i>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 8th. 1967</i> to <i>July 9 1967</i> . that (I) (we) last saw the deceased alive on <i>00:30 AM July 9th 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Pius Younghee Cho</i>				23B. DATE SIGNED <i>July 9th '67</i>	
23C. PHYSICIAN'S NAME (Type) <i>PIUS YOUNGHEE CHO</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9-12-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Wesley Freedom Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Sykesville Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 13 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>	
25C. FUNERAL DIRECTOR <i>Harry W. Haight</i>		25D. ADDRESS <i>Sykesville, Md.</i>			

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67. 6702

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 63-22678 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67. 6702

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) DOUGLAS K. ALT				2. DATE AND HOUR PRONOUNCED DEAD July 9, 1967 1:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Essex D. STREET ADDRESS (If rural, give location) 39 Langley Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH AUG. 24, 1963		9. AGE (In years last birthday) 3	If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) M.D.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DALE A. ALT				14. MOTHER'S MAIDEN NAME ROBERTA MYERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT DALE ALT		ADDRESS SAME	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E914.0 Electrocution ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 7-9-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) yard		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 39 Langley Road, Essex, Md. 53-00			
21D. TIME OF INJURY (APPROX.) 7-9-67 12:45 P.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? In barefeet grabbed hold of iron rod connected to extension cord, plugged into house current.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.				DATE SIGNED July 10, 1967			
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 7/12/67		23C. NAME OF CEMETERY or CREMATORY HOLLY HILL		23D. LOCATION (City, town, or county) (State) BALTO. MD.	
24A. DATE REC'D BY HEALTH DEPT. JUL 13 1967		24B. NAME OF REGISTRAR Robert E. Jackson		24C. FUNERAL DIRECTOR CONNELLY SONS		ADDRESS 300 MACE	

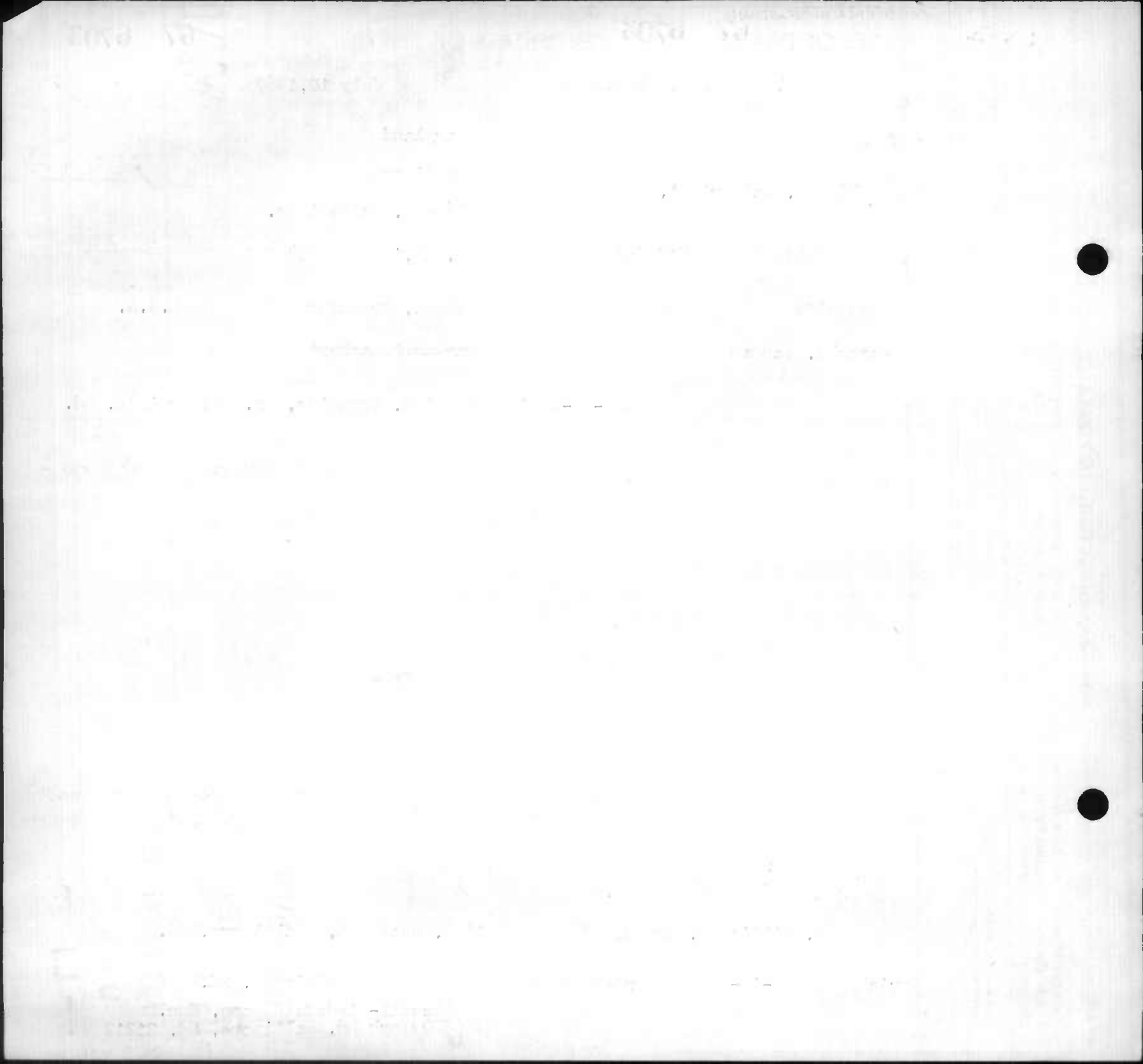
WILLIAM B. BOGGS

WILLIAM B. BOGGS

WILLIAM B. BOGGS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6703				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6703	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) MATTIE TAPPAN SPRAGINS				July 10, 1967 9:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 2622 N. Calvert St.				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				2622 N. Calvert St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Female	White	Widowed	Dec. 29, 1882	84			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Home		Helena, Arkansas		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James A. Tappan				Margaret Lambert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No			220-44-2841 T		Samuel H. Spragins, Jr. Lutherville, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 I				(A) Arteriosclerotic heart disease		5 years +	
ANTECEDENT CAUSES				(B) Generalized arteriosclerosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1950 to July 10 1967, that (I) (we) last saw the deceased alive on July 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. William G. Speed, III						July 11, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. William G. Speed, III				11 E. Chase St. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-13-67		Green Mount		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 13 1967		Robert E. Taylor, M.D.		Mitchell-Wiedefeld Home, Inc.		6500 York Rd. Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6704

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 6704

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MADOLYN G. LAYFIELD

2. DATE AND HOUR OF DEATH

July 10, 1967

8 PM

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

2630 N. Charles St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2630 N. Charles St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

Feb. 18, 1886

9. AGE (In years
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sales

10B. KIND OF BUSINESS OR INDUSTRY

Dept. Store

11. BIRTHPLACE (State or foreign country)

Frederick, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jerome Pampell

14. MOTHER'S MAIDEN NAME

Ariana Morgan

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-05-8584

17. INFORMANT

ADDRESS

A Mrs. Garrett O. Billmire 810 Evesham Ave.

18.

451X1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Hypertensive Arteriosclerotic Vascular Disease

5 yrs

(B) DUE TO

Abdominal Aneurysm

1 yr

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from 7/13/44 to 7/10 1967.
that (I) (we) last saw the deceased alive on 6/5 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Samuel Morrison

M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

7/11/67

23C. PHYSICIAN'S
NAME (Type)

Dr. Samuel Morrison

23D. ADDRESS

M.D.

11 E. Chase St. Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)
Burial

24B. DATE

7-13-67

24C. NAME OF CEMETERY or CREMATORY

Lorraine

24D. LOCATION

(City, town, or county)

Woodlawn, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 13 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Mitchell-Wiedefeld Home, Inc.

ADDRESS

6500 York Rd. Baltimore, Md. 21212

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67 6705

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67-11038

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6705

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ADRIAN

MORSELL

2. DATE AND HOUR PRONOUNCED DEAD

July 10, 1967

6:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL OR ADDRESS OR LOCATION)
INSTITUTION

Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Calvert Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Sunderland

D. STREET ADDRESS (If rural, give location)

Box 40

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

5-3-67

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

1 14

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Randolph Adams

14. MOTHER'S MAIDEN NAME

Mae Belle Morsell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Clifton Morsell -Sunderland- Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Aspiration of Stomach Contents
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

7-12-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Hope Ch. Cem.

23D. LOCATION

(City, town, or county)

Sunderland

Cal.

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 13 1967

Robert E. Farber, M.D.

Pinkney E. Sewell Prince Georges, Md.

WALTON & PRODIGES

W. & P.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6706		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6706	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Miss Melba Butz		2. DATE AND HOUR OF DEATH 7/17/67 2:45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md 21212	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL Hospital		D. STREET ADDRESS (If rural, give location) 41 Dunkirk Rd. 53-00			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 8/26/98	9. AGE (In years last birthday) 68	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Butz		14. MOTHER'S MAIDEN NAME Ida Hill		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-5810-A		17. INFORMANT Mrs Arthur Moore - sister - SAME AS 714	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH PELVIC CACINOMATOSIS		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION July 12, 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ANESTHESIA		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore Kardash		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/17/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 15, 67		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1967			
25B. NAME OF REGISTRAR Robert E. Fairley, M.D.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Townson, 1050 York Rd, Towson, Md.			

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67. 6707

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67. 6707

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ROY (ARCHIE) MARTIN 2. DATE AND HOUR PRONOUNCED DEAD July 10, 1967 5:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01

6. STREET ADDRESS (If rural, give location) 1015 Ensor Street

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED 8. DATE OF BIRTH OCT. 14 - 1914 9. AGE (In years last birthday) 52

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR 10B. KIND OF BUSINESS OR INDUSTRY SPRING & Comfort 11. BIRTHPLACE (State or foreign country) ROCKINGHAM COUNTY - N.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JESSIE MARTIN, SR. 14. MOTHER'S MAIDEN NAME MARY CARTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 242-03-9615 17. INFORMANT JESSIE MARTIN, JR. BOX 36 RFD 1 LEAKSVILLE, N.C. ADDRESS

18. 422.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic Cardiovascular Disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry [] Inspection [] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner []

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER [] ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER [] DATE SIGNED 7/11/67

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE July 14, 1967 23C. NAME OF CEMETERY or CREMATORY MT. CALVARY 23D. LOCATION (City, town, or county) (State) CEDAR HILL MD.

24A. DATE REC'D BY HEALTH DEPT. JUL 13 1967 24B. NAME OF REGISTRAR Robert E. Fagan 24C. FUNERAL DIRECTOR Donald E. Gloyer 24D. ADDRESS 1701-03 N. PATTERSON PARK AVE.

VS 151-REV. 1/1/65

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67. 6708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67. 6708

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

OCTAVIUS SWANN

2. DATE AND HOUR OF DEATH

July 10, 1967 5:25 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

39 Provident Hospital, Inc.
1514 Division Street
Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore,

D. STREET ADDRESS (If rural, give location)

1528 McCulloh Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11-18-1899

9. AGE (In years
last birthday)

67 yrs.

If Under 1 Yr. If Under 24 Hrs.
Months Oays Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Minnie /

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-07-1750

17. INFORMANT

Maude - Wife

ADDRESS

SAME

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

BRONCHOPNEUMONIA

(B) DUE TO

STRANGULATED HERNIA

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

DIABETES MELLITUS

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 4, 1967 to July 10, 1967,
that (I) (we) last saw the deceased alive on July 10, 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Malabrigo

M.D.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

7-10-67

23C. PHYSICIAN'S
NAME (Type)

J. Malabrigo,

M.D.

23D. ADDRESS

1514 Division Street Balto., Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-11-67

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 13 1967

Robert E. Fedyna

Charles R. Law, 802 Madison Ave.

RECEIVED
JAN 24 1964

U.S. DEPARTMENT OF JUSTICE

228-00-1000

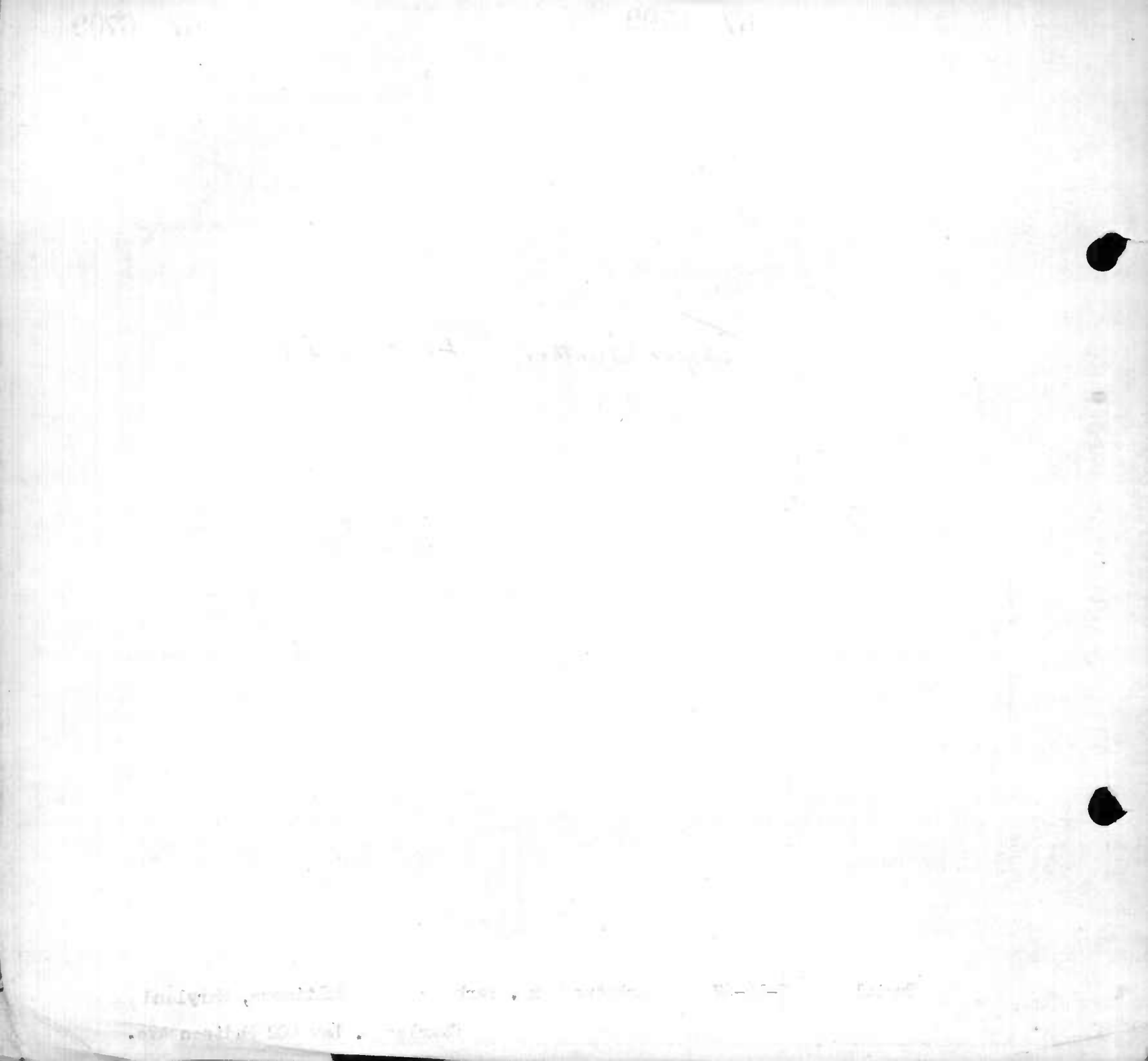
100-00-1000

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
JAN 24 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6709	
BIRTH NO. 67 6709		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MAXINE CLARK		2. DATE AND HOUR OF DEATH 7/12/67 7:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 3625 Rosedale Rd.		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-11	
		D. STREET ADDRESS (If rural, give location) 3625 Rosedale Rd.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 4/18/34	9. AGE (In years last birthday) 33	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown Jasper Gunther		14. MOTHER'S MAIDEN NAME Lois Reid	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-282117		17. INFORMANT Office Chart	
18. 430.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease & recurrent coronary insufficiency & old myocardial infarction		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 18 mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/27 19 67 to 7/12 19 67 , that (I) (we) last saw the deceased alive on 6/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elijah Saunders		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/12/67	
23C. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS		M.D. 23D. ADDRESS 3414 Duwall Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-16-67		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. ADDRESS			
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400 F-500		67 6710		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 6710	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				Beatrice M. Fann Bailey (Green)		7/10/67		4:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
1915 Edmondson Ave.				D. STREET ADDRESS (If rural, give location)		1915 Edmondson Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?			
Female	Colored	Widow		Aug. 3, 1888	78	U.S.A.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
						Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
John Greene				Mara Griffith					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				219-05-6823-0		Edward W. Dawson, 1915 Edmondson Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
442X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Respiratory failure					
ANTECEDENT CAUSES				(B) DUE TO Hemiplegia					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Hypertensive & arteriosclerotic C.V.R. disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 7/6/67 to 7/10/67, that (I) (we) last saw the deceased alive on 7/10/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		7/12/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
S. Borofsky				601 N. Howard St. Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		7-14-67		Arlington Mem. Park		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 13 1967		P. E. Farber		Charles E. Law, 802 Madison Ave.					

Station, New York (Green)

Station

Station

Station, New York

Station, New York

Station, New York

Station, New York

Station, New York

Station, New York, 1010 Station, New York

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6711	
BIRTH NO. 67 6711		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ella T. Snook		2. DATE AND HOUR OF DEATH July 10, 1967 3:45 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Ardleigh Nursing Home 2095 Rockrose Avenue		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2409 Linden Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Oct. 23, 1881	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Bookkeeper		10B. KIND OF BUSINESS OR INDUSTRY Grocers		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George Snook			
14. MOTHER'S MAIDEN NAME Edith Tensfield		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 215-03-9397		17. INFORMANT Mrs. Jean Free same address as above			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		15 yrs.			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Parkinson's syndrome		5 yrs.			
III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility		2 yrs.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 7, 1964 to July 10, 1967 , that (I) (we) last saw the deceased alive on July 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd E. Saylor</i> Lloyd E. Saylor M.D.				23B. DATE SIGNED July 12, 1967	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor M.D.				23D. ADDRESS 3902 Greenmount Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/1967		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1967			
25B. NAME OF REGISTRAR <i>Robert E. Fickner</i>		25C. FUNERAL DIRECTOR <i>Wm. J. Fickner & Sons</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6712 CERTIFICATE OF DEATH					Registered No. 67 6712				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) THOMAS S. DOYLE					2. DATE AND HOUR OF DEATH July 13, 1967 2:40 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOUR HOSPITAL 34					A. STATE MARYLAND				
(If not in hospital or institution, give street address or location)					B. COUNTY				
5. SEX MALE					6. RACE WHITE				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED					8. DATE OF BIRTH 8/16/1890				
9. AGE (In years last birthday) 76					10. If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus. Agent					10B. KIND OF BUSINESS OR INDUSTRY Structural Steel				
11. BIRTHPLACE (State or foreign country) New York City					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JOHN DOYLE					14. MOTHER'S MAIDEN NAME HELEN ...				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT St. chart					ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 422.1 I Arteriosclerosis Cordis Vascul. Disease.					INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from July 10 1967 to July 13 1967 , that (I) (we) lost saw the deceased alive on July 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Resar A. Bravo					23B. DATE SIGNED July 13, 1967				
23C. PHYSICIAN'S NAME (Type) RESAR A. BRAVO					23D. ADDRESS BON SECOUR HOSP.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7/15/1967				
24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1967					25B. NAME OF REGISTRAR R. E. Farkner				
25C. FUNERAL DIRECTOR Wm. F. Farkner & Sons					ADDRESS Dale, Md.				

BY ORDER OF THE SECRETARY OF THE ARMY

WASHINGTON, D.C.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6713	
67 6713 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Aginora Walters	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		2. DATE AND HOUR OF DEATH	
		A. STATE Md		July 11, 1967 3:47-A M.	
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
D.O.A.		Baltimore		1627 N. Caroline St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	Colored	Married	March 10, 1900	67	Domestic
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		N. Carolina			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Holder Rowland		Sallie Atkinson		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		Henry Walters		1627 N. Caroline St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		15 yrs	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		Diabetes mellitus			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Bronchial asthma			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from July 10 to July 11, 1967, that (I) (we) lost saw the deceased alive on June 27, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				7.11.67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)	
RAYNER BROWNE, M.D. 1500 EAST MADISON ST. BALTIMORE, MD. 21205				Burial	
24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
July 15/67		Carron Memorial Park		Lanier Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 13 1967		Robert E. Taylor, M.D.		Zyphor T. Elikens 11297 Curtis	

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Hydrogen peroxide
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Hydrogen peroxide
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1700 EAST MADISON ST
CHICAGO, ILL. 60604

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6714		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6714	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) EISER, EDGAR LEROY-SR.			7-12-67 6:00AM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL			A. STATE MARYLAND		
			B. COUNTY Balto. C		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21207 53-00		
			D. STREET ADDRESS (If rural, give location) 7226 FAIRBROOK ROAD		
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH Apr. 2, 1897	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10B. KIND OF BUSINESS OR INDUSTRY Balto. City	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Charles Eiser			14. MOTHER'S MAIDEN NAME Louise Groff		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-22-5351	17. INFORMANT ADDRESS Robert L. Eiser 7226 Fairbrook Rd.		
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA METASTATIC ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) ADENOCARCINOMA METASTATIC DUE TO (B) Primary - Kidney DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH about 1 year
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-3-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED intestinal obstruction		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carl A. Matthey				23B. DATE SIGNED 7/12/67	
23C. PHYSICIAN'S NAME (Type) C. MATTHEY				23D. ADDRESS ST. AGNES HOSP; CATON & WILKENS AVES. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-1967		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION Woodlawn, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Howard B. Howard Long Term Home - Balto. Md.			

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ST. ALICE HOSPITAL

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6715	
BIRTH NO.		67 6715		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Beever, Irene</i>		2. DATE AND HOUR OF DEATH <i>July 10, 1967</i> <i>1:45 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3925 Mt. Pleasant Avenue 21224</i>		5. AGE (In years last birthday) <i>50</i> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>2-7-1917</i>	9. AGE (In years last birthday) <i>50</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plastics</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Wamco Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Walter Ogelsby</i>		14. MOTHER'S MAIDEN NAME <i>Eva Perry</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-20-5932</i>		17. INFORMANT <i>RECORDS: BCH 4940 Eastern Avenue 21224</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>330 X I</i> <i>Subarachnoid hemorrhage</i>		CAUSE OF DEATH (A) <i>Subarachnoid hemorrhage</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>54 1/2 hours</i>			
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>None</i>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>None</i>			
19A. DATE OF OPERATION <i>2 none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>None</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>None</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>None</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>None</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>July 7th</i> 19 <i>67</i> to <i>July 10th</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>July 10th</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jack Brandes M.D.</i>				23B. DATE SIGNED <i>JULY 10, 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>JACK BRANDES</i>				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS</i> <i>BALTIMORE, MD. 21224 4940 Eastern Avenue</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-13-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>JUL 13 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>John C. Miller Inc</i>		25D. ADDRESS <i>6415 Belair Rd. -21206</i>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6716</u>	
BIRTH NO. <u>67 6716</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>JULY 10, 1967</u> <u>2</u> P. <u>M.</u>			
1. NAME OF DECEASED (Type or Print) <u>NATHAN AARON SILVERMAN</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION <u>3321 OLYMPIA AVENUE</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3321 OLYMPIA AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 4, 1888</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>AARON SILVERMAN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MRS. BESSIE SILVERMAN, 3321 OLYMPIA AVENUE</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma, Stomach @ 1 1/2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acid</u>					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION <u>9-16-1939</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-16-1939</u> to <u>7-10-1967</u> , that (I) <u>we</u> last saw the deceased alive on <u>7-5-1967</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley Steinbach</u> M.D.		23B. DATE SIGNED <u>July 10, 1967</u>			
23C. PHYSICIAN'S NAME (Type) <u>DR. STANLEY STEINBACH</u>		23D. ADDRESS <u>11 SLADE AVENUE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/11/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>KNESSETH ISRAEL KOLK WOLYN</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1967</u>			
24F. NAME OF REGISTRAR <u>Robert E. Taylor</u>		24G. FUNERAL DIRECTOR <u>OL LEVINSON & BROS. INC., 6010 REIST., RD.</u>			

RECEIVED

RECEIVED

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67. 6717 CERTIFICATE OF DEATH					Registered No. 67 6717				
BIRTH NO. 15-536									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) SANDERS FRANK					2. DATE AND HOUR OF DEATH 7-10-67 1345 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 2511 Reisterstown Road 21217				
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-30-1900	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co		11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Sanders					14. MOTHER'S MAIDEN NAME Zadia Sanders				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-05-5095		17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Respiratory Insufficiency DUE TO Chronic Obstructive Pulm Dis. DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. None					INTERVAL BETWEEN ONSET AND DEATH				
MEDICAL CERTIFICATION									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None									
19A. DATE OF OPERATION 7-13-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) 5		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? NO				
22. I certify that (I) (this hospital) attended the deceased from 6-22 19 67 to 7-10 19 67 , that (I) (we) last saw the deceased alive on 7-9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Patrick Desmond					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 7-10-67	
23C. PHYSICIAN'S NAME (Type) Patrick Desmond					23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-67		24C. NAME OF CEMETERY or CREMATORY Georgetown Ch. Cem.			24D. LOCATION (City, town, or county) (State) Scranton N.C.		
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1967		25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Horning Dyett F.H.			ADDRESS 1701 Laurens St	

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67. 6718

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67. 6718

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHESTERFIELD PARKER				2. DATE AND HOUR PRONOUNCED DEAD July 12, 1967 3:50 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 400 N. Fulton Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 27-17 D. STREET ADDRESS (If rural, give location) 2822 Garrison Avenue			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH 10-14-1916	9. AGE (In years last birthday) 50	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER		10B. KIND OF BUSINESS OR INDUSTRY Checker Cab Co.		11. BIRTHPLACE (State or foreign country) HASSEL, NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK.				14. MOTHER'S MAIDEN NAME LIZZIE PARKER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-14-6652		17. INFORMANT Mrs. Lillian Parker		ADDRESS 2622 Loyola Norwa	
18. E981X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) MASSIVE bilateral hemothorax CAUSE OF DEATH (A) DUE TO Puncture of lungs, pulmonary artery and aorta (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 400 N. Fulton Ave. doorway of office of Checker Cab Co.			
21D. TIME OF INJURY (APPROX.) 7 12 67 3:35 a.m.		21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Subject shot in chest			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D.							
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 7-17-67		23C. NAME of CEMETERY or CREMATORY Balto National Cem.		23D. LOCATION (City, town, or county) (State) Baltimore Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR Robert E. Fisher		24C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.			

JUL 13 1967 67. 6718

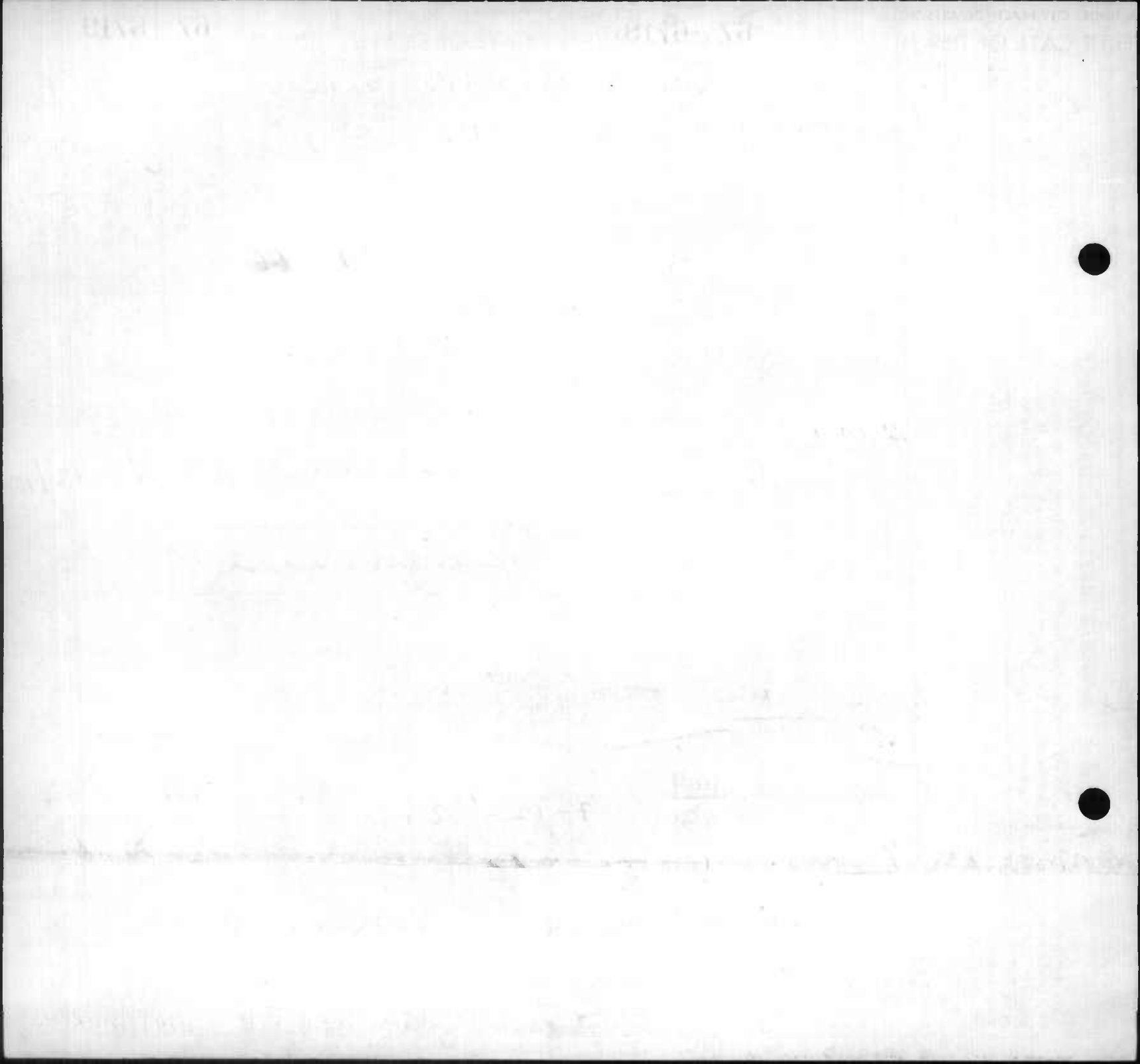
ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-2000 BY 100-100000



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6719</u>	
BIRTH NO. <u>67 6719</u>		67 6719		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Shelton, Phillip H.</u>		2. DATE AND HOUR OF DEATH <u>7-12-67</u> <u>12.30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Lutheran Hospital</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>City</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u>	
46		D. STREET ADDRESS (If rural, give location) <u>3221 Westmont Ave</u>		<u>16-07</u>	
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>5-22-1901</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BeThel Church</u>		11. BIRTHPLACE (State or foreign country) <u>Blackstone, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>John Shelton</u>		14. MOTHER'S MAIDEN NAME <u>Rose Smith</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>229-09-5047</u>		17. INFORMANT <u>Mrs. Mary Crawley</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Myocardial Infarction 7/3-12/67</u>		19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <u>Hypertensive atherosclerotic vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7/3-12/67</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-3-1967</u> to <u>7-12-1967</u> that (I) (we) last saw the deceased alive on <u>7-12-1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nevzat Turkman</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7-12-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Nevzat Turkman</u>		23D. ADDRESS <u>Lutheran Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-16-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Blackstone Church Cem.</u>	
24D. LOCATION <u>Blackstone Va.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Myrlon E. Dyett F.H.</u>		25D. ADDRESS <u>1701 Laurens</u>			



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SARAH JANE JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

July 8, 1967 7:20 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL D.O.A.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1105 N. Gilmore Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

SEPARATED

8. DATE OF BIRTH

5-22-1924

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LAUNDRESS

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

KEMBRIDGE, VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WALTER WILSON

14. MOTHER'S MAIDEN NAME

ALICE WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-24-4771

17. INFORMANT

ADDRESS

Mrs. Nancy McDougald 1802 Warwick Ave

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Heart DiseaseANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

July 9, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-15-67

23C. NAME OF CEMETERY or CREMATORY

Mount Auburn Cem.

23D. LOCATION

Baltimore,

(City, town, or county)

Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St.

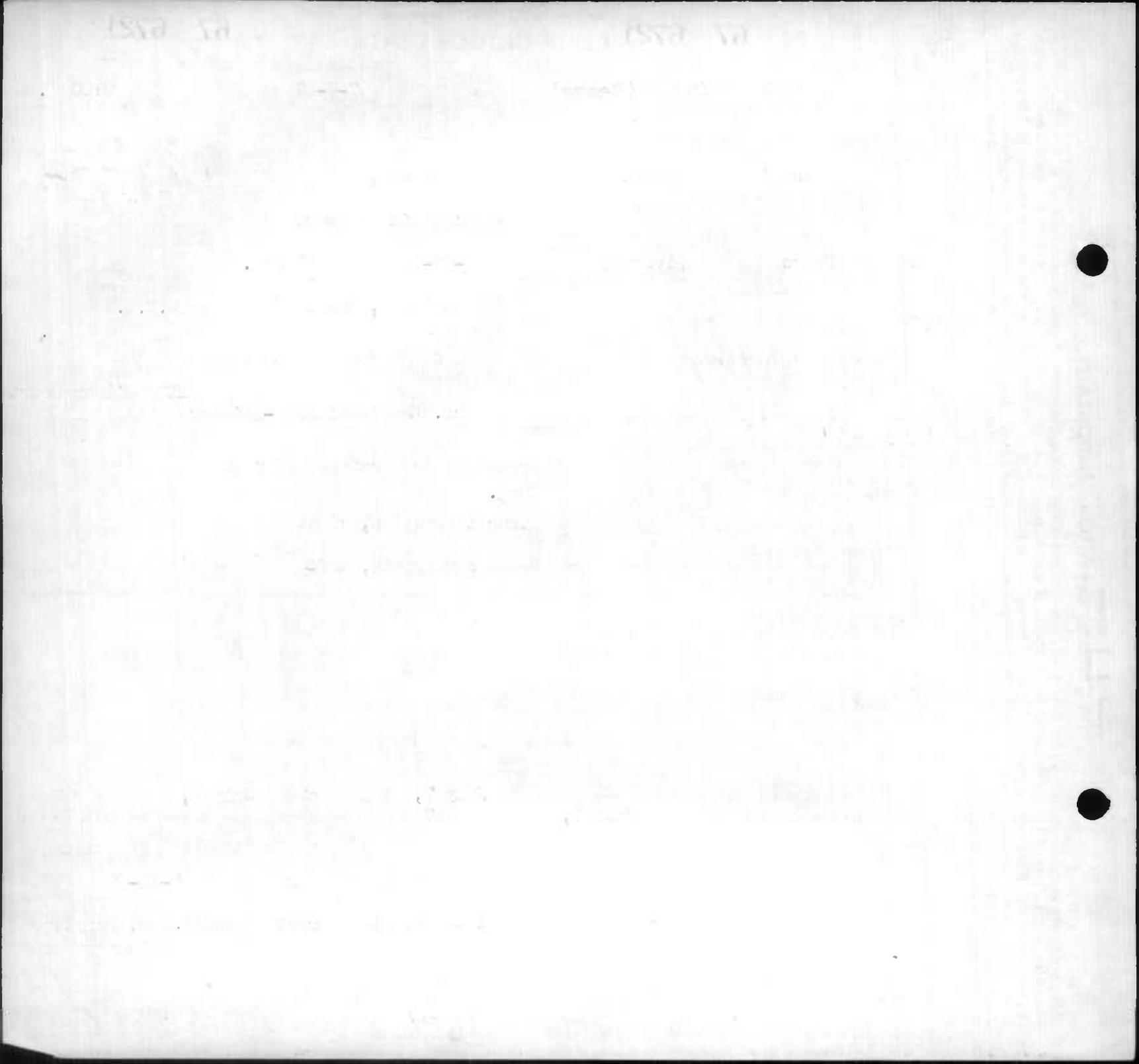
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6721 CERTIFICATE OF DEATH					Registered No. 67 6721				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Rees Whiting (Reese)					2. DATE AND HOUR OF DEATH 7-9-67 9:00 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital					A. STATE Maryland				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write R.U. for rural, give township) Baltimore, 17-02				
D. STREET ADDRESS (If rural, give location) 1130 Wilmer Court									
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 2-22-10	9. AGE (In years last birthday) 57 yrs.	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Whiting					14. MOTHER'S MAIDEN NAME Charity Evans				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Bessie Wilson - Sister				
					ADDRESS 1124 Wilmer Court City # 21207				
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Bronchogenic carcinoma of right lung. (B) Pleural effusion, right (C) Bronchopneumonia, left					INTERVAL BETWEEN ONSET AND DEATH				
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 7, 1967 to July 9, 1967 , that (I) (we) last saw the deceased alive on July 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE ATA Amini					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-10-67		
23C. PHYSICIAN'S NAME (Type) ATA Amini					23D. ADDRESS 1514 Division Street Baltimore, Maryland				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-13-67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) A. A. Co. Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Myron Dyer F.H.		ADDRESS 1701 Laurens			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6722	
67 6722				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Patrick F. O'Malley	
2. DATE AND HOUR OF DEATH		7-12-67 7:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
37 Mercy Hospital.		Md. BALTIMORE 12-01			
D. STREET ADDRESS (If rural, give location)		3601 Greenway			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W	Married	12-28-85	81	Executive
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Insurance		Md	U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Edward F. O'Malley			Mary Lee O'Toole		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			220-32-3089A		Paul T. O'Malley Balto., Md
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			(A) Coronary heart disease		
ANTECEDENT CAUSES			(B) ACUTE MASSIVE MYOCARD. INFARCTION		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0 NONE					NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
JULY 10, 1967	40	White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 10 19 67 to July 12 19 67, that (I) (we) last saw the deceased alive on July 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
(Signature)				7-13-67	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Fernando B. Cannon			Mercy Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial		7-15-67	New Cathedral		Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 14 1967		Robert E. Fairman		H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	

General and Special

General and Special

General and Special

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General and Special

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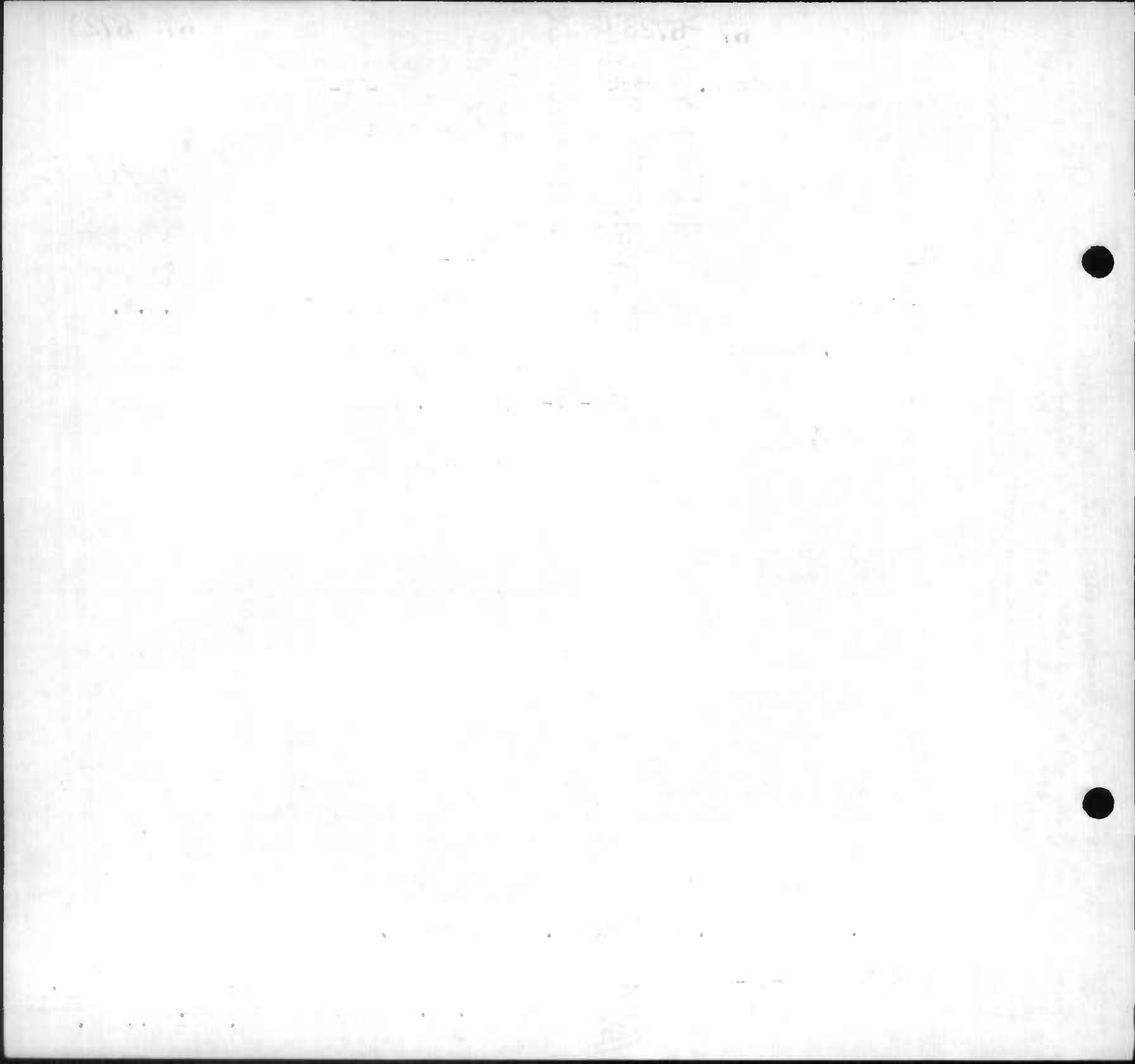
10

General and Special

General and Special

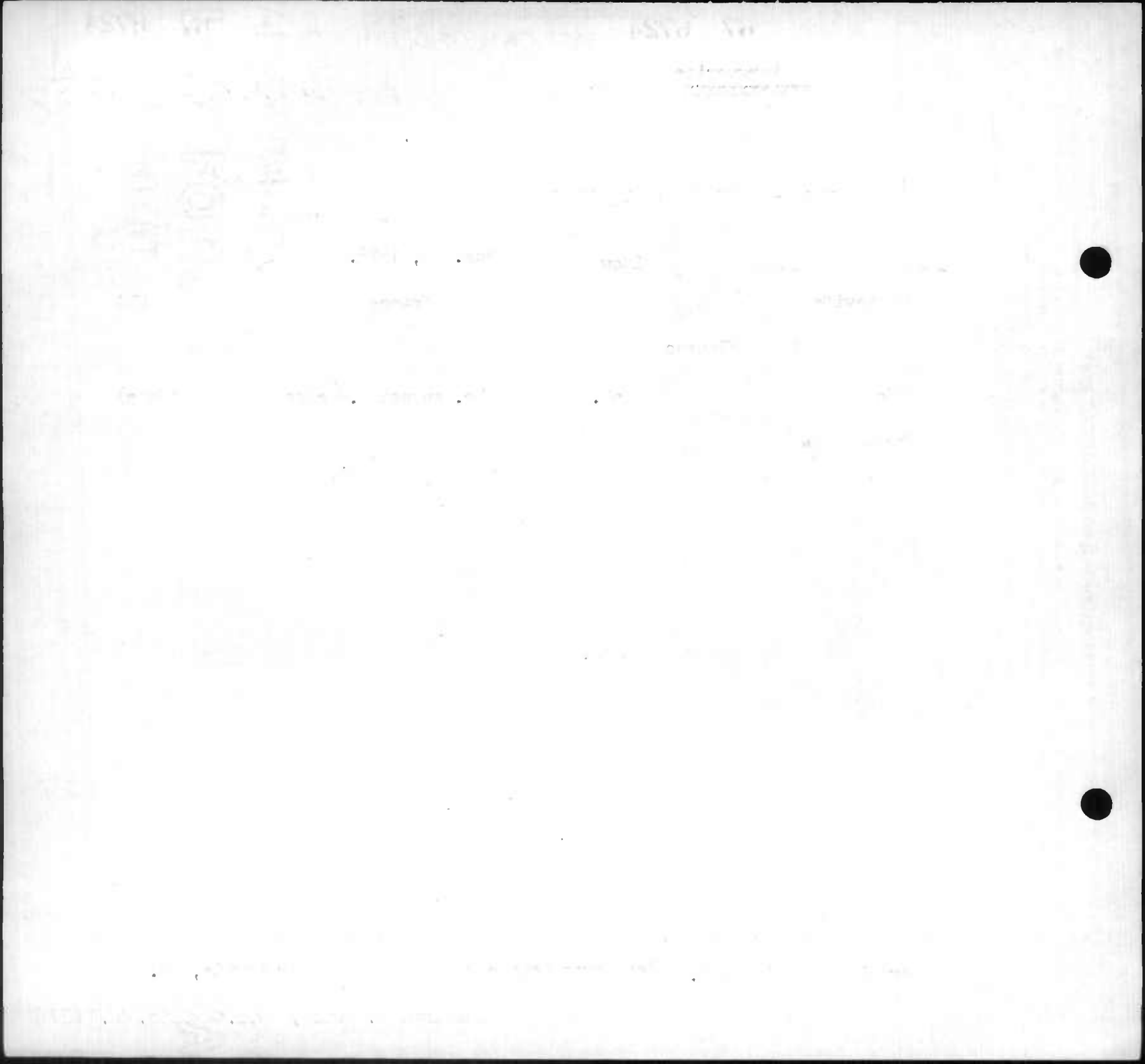
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6723 CERTIFICATE OF DEATH					Registered No. 67 6723				
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 6723</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) Edwin F. Barock (H)</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 7-11-67 5³⁰_P M.</p> </div> </div>									
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 1.2em;">1520 Medford Road</p>					<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland</p> <p>B. COUNTY</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</p> <p style="font-size: 1.2em;">Baltimore</p> <p>D. STREET ADDRESS (If rural, give location)</p> <p style="font-size: 1.2em;">1520 Medford Road</p>				
<p>5. SEX M</p>		<p>6. RACE W</p>		<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</p> <p style="font-size: 1.2em;">Married</p>		<p>8. DATE OF BIRTH 3-7-1910</p>		<p>9. AGE (In years last birthday) 57</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 1.2em;">Broker</p>					<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p style="font-size: 1.2em;">Candy</p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p style="font-size: 1.2em;">Baltimore, Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="font-size: 1.2em;">U.S.A.</p>
<p>13. FATHER'S NAME</p> <p style="font-size: 1.2em;">Frank J. Barock</p>					<p>14. MOTHER'S MAIDEN NAME</p> <p style="font-size: 1.2em;">Sophia Bruha</p>				
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="font-size: 1.2em;">No</p>					<p>16. SOCIAL SECURITY NO.</p> <p style="font-size: 1.2em;">212-22-3941</p>		<p>17. INFORMANT</p> <p style="font-size: 1.2em;">Mrs. Jean Barock</p>		<p>ADDRESS</p> <p style="font-size: 1.2em;">Same</p>
<p>18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)</p> <p style="font-size: 1.2em;">CAUSE OF DEATH</p> <p style="font-size: 1.5em;">Carcinoma lung</p> <p>(A) DUE TO</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION (s).</p> <p>(B) DUE TO</p> <p>(C)</p> <p>INTERVAL BETWEEN ONSET AND DEATH</p>									
<p>19. DATE OF OPERATION 0</p> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>20A. AUTOPSY? (Yes or No) No</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>									
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>				<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>				<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from March 26 19 64 to July 11 19 67.</p> <p>that (I) (we) last saw the deceased alive on July 11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>									
<p>23A. SIGNATURE Dr. Anderson M. Renick, Jr.</p>					<p>M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>		<p>23B. DATE SIGNED 7/12/67</p>		
<p>23C. PHYSICIAN'S NAME (Type)</p> <p style="font-size: 1.2em;">Dr. Anderson M. Renick, Jr.</p>					<p>23D. ADDRESS</p> <p style="font-size: 1.2em;">1010 St. Paul Street</p>				
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="font-size: 1.2em;">Burial</p>		<p>24B. DATE</p> <p style="font-size: 1.2em;">7-14-67</p>		<p>24C. NAME of CEMETERY or CREMATORY</p> <p style="font-size: 1.2em;">Holy Redeemer Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p style="font-size: 1.2em;">Baltimore, Md.</p>			
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="font-size: 1.2em;">JUL 14 1967</p>		<p>25B. NAME OF REGISTRAR</p> <p style="font-size: 1.2em;">R. E. Jenkins</p>		<p>25C. FUNERAL DIRECTOR</p> <p style="font-size: 1.2em;">H. W. Jenkins & Sons Co.</p>		<p>ADDRESS</p> <p style="font-size: 1.2em;">4905 York Rd. Balto., Md. 21212</p>			



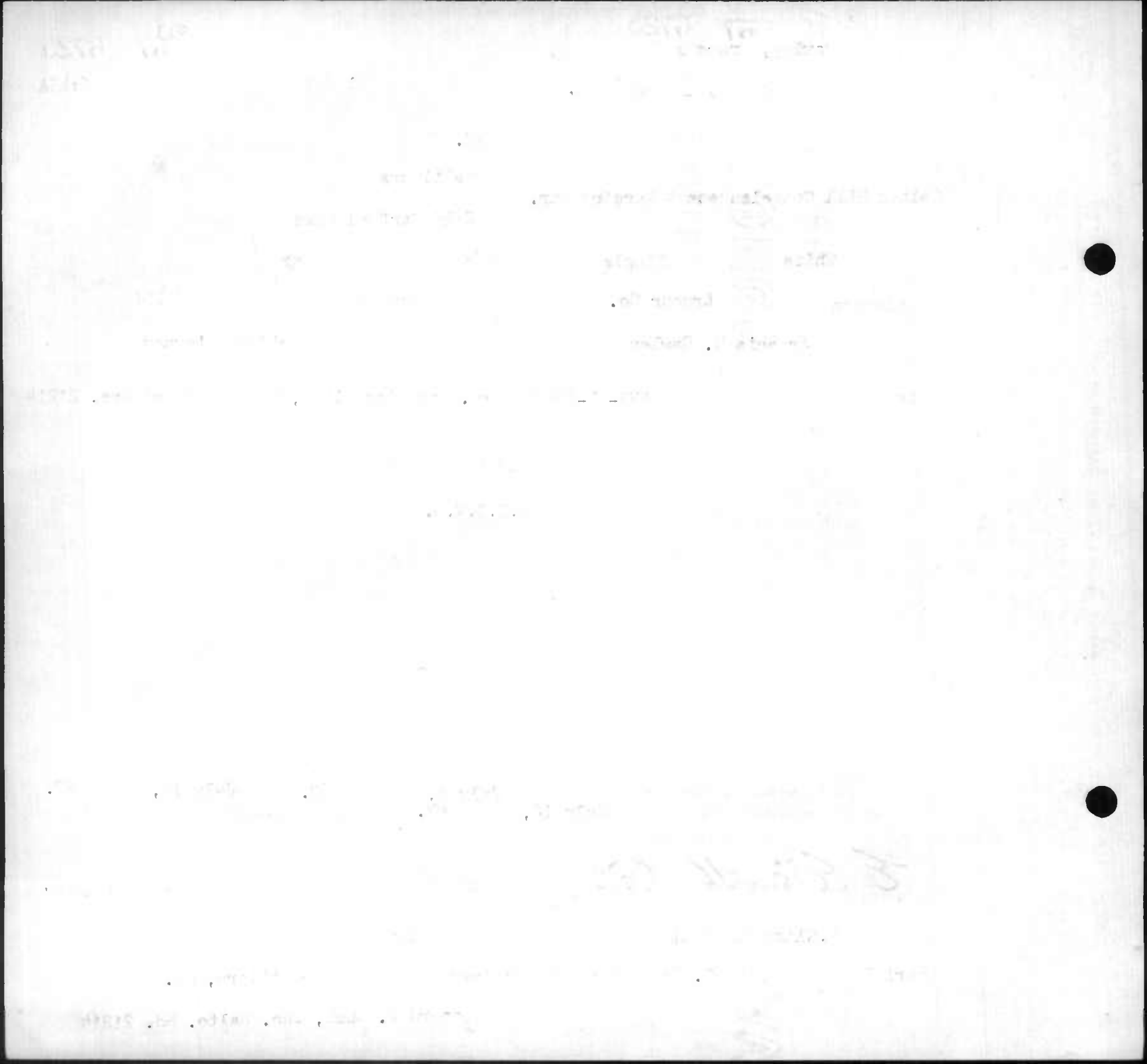
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6724	
BIRTH NO. 67 6724		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Marguerite De Vos		2. DATE AND HOUR OF DEATH July 13, 1967. 6:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-03		
			D. STREET ADDRESS (If rural, give location) 5211 Tramore Road		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Aug. 25, 1876.	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) France	
13. FATHER'S NAME ? Flourac			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT ADDRESS Mr. August H.D. eVos (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 260X-1			CAUSE OF DEATH (A) DUE TO arteriosclerotic Heart Disease (B) DUE TO arteriosclerotic (C) DUE TO Hypertension and Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of femur		
19A. DATE OF OPERATION May 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 5, 1967 to July 13, 1967 , that (I) (we) last saw the deceased alive on July 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donno W. M. Wozner			23B. DATE SIGNED 7/13/67		
23C. PHYSICIAN'S NAME (Type) Donno W. M. Wozner			23D. ADDRESS 3009 EVER GREEN AVE BALTO MD 21214		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/67.		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery	
				24D. LOCATION (City, town, or county) (State) Glenburnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>913</u>	
BIRTH NO. <u>67 6725</u>		CERTIFICATE OF DEATH		67 6725	
M.E. CASE NO. <u>Cawley, Francis</u>					
1. NAME OF DECEASED (Type or Print) <u>Cawley, Francis A.</u>		2. DATE AND HOUR OF DEATH <u>7/12/67</u>		<u>6:45A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bolton Hill Convelescent & Nursing Ctr.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>9-06</u> D. STREET ADDRESS (If rural, give location) <u>2926 Harford Road</u>			
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>7/8/83</u>	9. AGE (In years last birthday) <u>84</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Armour Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Francis R. Cawley</u>			14. MOTHER'S MAIDEN NAME <u>Bridget Tierney</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-07-1643A</u>		17. INFORMANT ADDRESS <u>Mrs. Rae Litchfield, 3013 Fleetwood Ave. 21214</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>134X I</u> <u>Carcinoma rectum</u> <u>A.S.C.V.D.</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>July 5, 1967</u> to <u>July 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 12, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Ellsworth Cook</u> M.D.		23B. DATE SIGNED <u>July 12, 1967.</u>			
23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook</u> M.D.		23D. ADDRESS <u>2431 Maryland Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/14/67.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	



67 6726

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6726

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARRY C. WECKESSER

2. DATE AND HOUR PRONOUNCED DEAD

July 12, 1967

11:42 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 2616 Lehman Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2616 Lehman Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Sept. 22, 1893

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Trucking

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Weckesser

14. MOTHER'S MAIDEN NAME

Annie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

NONE

16. SOCIAL
SECURITY NO.

216-05-7117

17. INFORMANT

ADDRESS

Matilda Weckesser 2616 Lehman St.

18. E 904, 10

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)Bilateral bronchopneumonia complicating
fracture of upper right humerus

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2616 Lehman Street

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

7-8-67

?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell in kitchen of home

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-17-67

23C. NAME OF CEMETERY or CREMATORY

GLEN HAVEN

23D. LOCATION (City, town, or county)

GLEN BURNIE, MD

24A. DATE REC'D BY HEALTH DEPT.

JUL 14 1967

24B. NAME OF REGISTRAR

Robert E. Fawcett, M.D.

24C. FUNERAL DIRECTOR

Geo. L. Schwab Funeral Home

ADDRESS

Francis D. Miller 2101 Frederick Ave.

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6727	
BIRTH NO. 67 6727		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Geo A. M. Hagedorn		2. DATE AND HOUR OF DEATH July 6, 67 9 9 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 002804 List Ave		A. STATE M B. COUNTY Balto			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 27-02			
		D. STREET ADDRESS (If rural, give location) 2804 List Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH Apr 12, 1877	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto	
13. FATHER'S NAME Geo		14. MOTHER'S MAIDEN NAME E. Kubatzke			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 215-09-2635		17. INFORMANT Mrs John Lemback	
				ADDRESS Same	
18. I 157 X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 3 mos	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Paresis		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 6 - 1942 to July 6, 1967 , that (I) (we) last saw the deceased alive on July 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE George Sawyer				23B. DATE SIGNED July 7 - 67	
23C. PHYSICIAN'S NAME (Type) GEORGE SAWYER				23D. ADDRESS 4808 Harford Rd.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7/8/67		24C. NAME of CEMETERY or CREMATORY Immanuel	
				24D. LOCATION (City, town, or county) (State) Balto	
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Robert E. Sawyer		25C. FUNERAL DIRECTOR Ed. Ziemann	
				ADDRESS 6067 Harf Rd	

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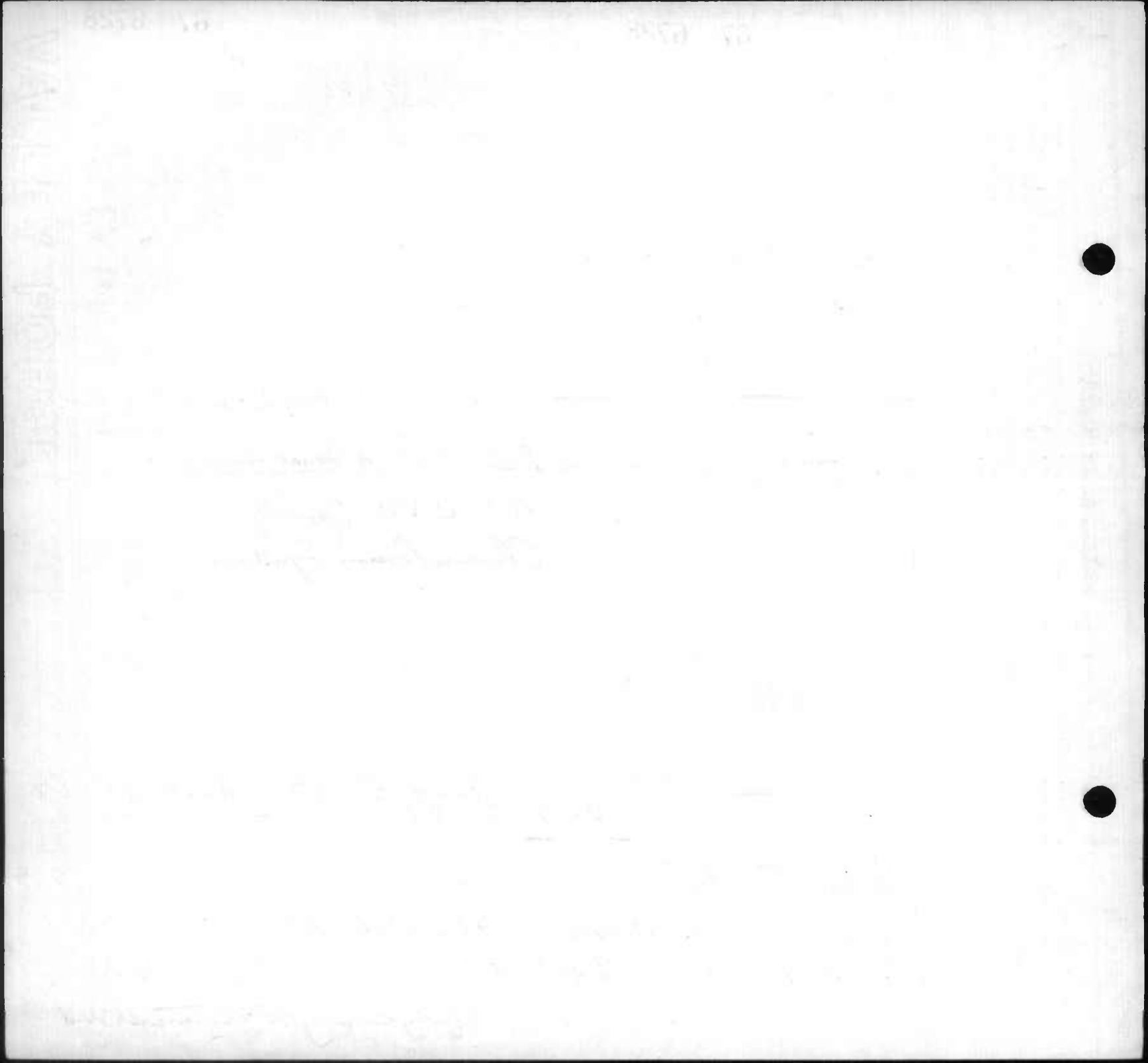
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6728	
BIRTH NO. 67 6728		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANDREWETTE A. STOCK		2. DATE AND HOUR OF DEATH 7/8/67 - 11:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND - BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229 D. STREET ADDRESS (If rural, give location) 405 ROCK GLEN ROAD			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-12-1877	9. AGE (In years last birthday) 89 YRS.	10. Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME AUGUST HESSLER		14. MOTHER'S MAIDEN NAME EMMA MOSEMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Andriette Compton - 405 Rock Glen Rd	
18. 422.11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) PNEUMONIA - HEART FAILURE DUE TO			
		(B) ASCVD - Generalized DUE TO			
		(C) Chronic Brain Syndrome DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 5 1967 to JULY 8 1967 , that (I) (we) last saw the deceased alive on JULY 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John F. Hartman M.D.				23B. DATE SIGNED July 8, 1967	
23C. PHYSICIAN'S NAME (Type) JOHN F. HARTMAN M.D.				23D. ADDRESS 422 MED. ARTS BLDG 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-67		24C. NAME OF CEMETERY or CREMATORY Catholic Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967			
25B. NAME OF REGISTRAR John F. Hartman		25C. FUNERAL DIRECTOR John F. Hartman			
25D. ADDRESS 405 Rock Glen Rd					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6729 CERTIFICATE OF DEATH					Registered No. 67 6729				
BIRTH NO.					DATE AND HOUR OF DEATH				
M.E. CASE NO.					07X08X67 7 10 67 1:45 A.M.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
EMMA LOUISE FIFER									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE				
					B. COUNTY				
40 ST AGNES HOSPITAL					MARYLAND				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE				
					D. STREET ADDRESS (If rural, give location)				
					435 S PARADISE AVE				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.		
FEMALE	WHITE	SEPARATED	09/26/01	65					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
RETIRED - HOUSEKEEPER			HOTEL		BALTIMORE, MD		U S		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
FRANK BALLADARSCH					MARY HERTZIG				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT		
NO					220-26-9909		ST AGNES HOSPITAL RECORDS		
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH				
					Cerebral Thrombosis ASCUP				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
D					NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that <u>XIX</u> (this hospital) attended the deceased from <u>7/9</u> 19 <u>67</u> to <u>7/10</u> 19 <u>67</u> , that <u>X</u> (we) last saw the deceased alive on <u>7/10</u> 19 <u>67</u> and that in <u>X</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) <u>X</u> (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
<u>George J. Patrick</u> M.D.					7/10/67				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
GEORGE PATRICK					ST AGNES HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
Burial			7-14-67		Woodland Cemetery		6601 Frederick Rd		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
JUL 14 1967			R. E. E. Taylor			Harley Cavanaugh			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 08-14-97 BY SP6 BTJ/KJS

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BIRTH NO. 67 6730		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6730	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) O'Connor, Mrs. Eleanor B.			2. DATE AND HOUR OF DEATH July 9, 1967 9:50 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore Co.		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21229 53-00		
			D. STREET ADDRESS (If rural, give location) 833 Braeside Rd.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-24-92	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Wm. Strider		
14. MOTHER'S MAIDEN NAME Hartman			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Husband ADDRESS ASBE EDWARD J. O'CONNOR - SAME AS		
18. 20011 CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH 31 days		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Pneumonia			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Lymphosarcoma			(B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none			(C)		
19A. DATE OF OPERATION 20011		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 24th June 19 67 to 9th July 19 67 , that (I) (we) last saw the deceased alive on 9th July 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Byung Kap Kang M.D.				23B. DATE SIGNED 9th July, 1967	
23C. PHYSICIAN'S NAME (Type) BYUNG KAP KANG M.D.				23D. ADDRESS Bon Secours Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-65		24C. NAME OF CEMETERY or CREMATORY Cathedral Cn.	
24D. LOCATION (City, town, or county) Baltimore		25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR John C. Gorman ADDRESS 24th Baltimore St., Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT					
BIRTH NO.			Registered No.		
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
GRENTZ, ELEANOR M			JULY 9, 1967 11:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229			A. STATE B. COUNTY MARYLAND 21227 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4926 LEEDS AVENUE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	WHITE	WIDOWED	5/8/77	90	HOUSEWIFE
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
NONE			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
UNKNOWN DEC'D			UNKNOWN DEC'D		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO			214 54 9733		
17. INFORMANT			ADDRESS		
HOSPITAL RECORDS-ST. AGNES HOSPITAL					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Central Hemorrhage (B) Atherosclerosis (C) INTERVAL BETWEEN ONSET AND DEATH					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work Not While At Work		
21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from JULY 6, 1967 to JULY 9, 1967 that (we) last saw the deceased alive on JULY 9, 1967 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
GABRIEL BRAUN			7/9/67		
23C. PHYSICIAN'S NAME (Typo)			23D. ADDRESS		
GABRIEL BRAUN			ST AGNES HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
Burial			7-13-67		
24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Landon Park Cem.			Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
JUL 14 1967			R. G. E. Taylor, M.D.		
25C. FUNERAL DIRECTOR			ADDRESS		
T. J. Arnsperg & Co.			1100 N. Calver St., Baltimore, Md.		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6732</u>	
BIRTH NO. <u>67 6732</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WARREN, LELIA</u>		2. DATE AND HOUR OF DEATH <u>7/10/67</u> <u>8:40 P M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MARYLAND GENERAL HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>Balts. Co.</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>8925 Carlisle Avenue 21236</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>6/20/81</u>	9. AGE (In years last birthday) <u>86</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>THOMAS JONES</u>		14. MOTHER'S MAIDEN NAME <u>HELEN RICHARDSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-46-3194</u>		17. INFORMANT ADDRESS <u>Mr Philip Warren 8925 Carlisle Avenue</u>	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ASCVD</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CHF with Pulmonary Edema</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard H. Bard</u> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/10/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>RICHARD H. BARD</u> M.D.		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7-14-1967</u>	24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Lansing Funeral Home 7401 Belair Road</u>	

Warren, Cecil

7/10/27

2:40 P

Widowed

Bartholomew

Bartholomew General Hospital

2450 3rd St

6/20/21 84

Widowed

White

Female

None

Thomas Jones

Jones

Helen Richardson

Widowed

U.S.A.

No

Widowed

Off with Primary Ed.

Richard H. Bond

Richard H. Bond

7/10/27

✓

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6733	
BIRTH NO. 67 6733		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GROSS, DAVID		2. DATE AND HOUR OF DEATH 7-11-67 8:27 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP OF BALTIMORE INC.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 2715 CHLER AVE #15	
5. SEX MALE	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JAN 8, 23	9. AGE (In years last birthday) 44	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY MANUFACTURERS		11. BIRTHPLACE (State or foreign country) N.Y., N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BENJAMIN GROSSHANDLER		14. MOTHER'S MAIDEN NAME DORA ITZKOWITZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 075-16-6332		17. INFORMANT WIFE, Bernice Gross	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.11		CAUSE OF DEATH (A) UREMIA (B) RENAL FAILURE (C) MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 12 HRS 48 HRS 4 DAYS	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) No		21E. INJURY OCCURRED While At <input type="checkbox"/> No Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? No	
22. I certify that (I) (this hospital) attended the deceased from 7-7 19 67 to 7-11 19 67 , that (I) (we) last saw the deceased alive on 7-11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE SETH PARKER		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-11-67	
23C. PHYSICIAN'S NAME (Type) SETH PARKER		23D. ADDRESS M.D. SINAI HOSP OF BALTIMORE, INC			
24A. BURIAL CREMATION, REMOVAL (Specify) 7-12-67 Burial		24B. DATE 7-12-67		24C. NAME OF CEMETERY or CREMATORY Greenwood	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Robert E. Falek, M.D.	
25C. FUNERAL DIRECTOR John J. Quinn & Bros Inc. Rd.		25D. ADDRESS 6000 Hunt			

Yes will

Benjamin Franklin

Dear Sir

London, N.Y.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) A fracture of any kind; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. 67 6734						
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67-13222 67. 6734 4 </div>											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>Baby Gail Poole</u>					2. DATE AND HOUR OF DEATH <u>7-11-67</u> <u>6:35 P</u> M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where decedent lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE <u>MD</u> B. COUNTY						
<u>UNION MEMORIAL HOSPITAL</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore MD</u>						
					D. STREET ADDRESS (If rural, give location) <u>3006 Oakcrest Ave</u>						
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NM</u>	8. DATE OF BIRTH <u>7-11-67</u>	9. AGE (In years last birthday) <u>12 hours</u>	10. UNDER 1 Yr. Months: Days	11. UNDER 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>			10B. KIND OF BUSINESS OR INDUSTRY —			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Elbert Corbe</u>					14. MOTHER'S MAIDEN NAME <u>Dorothy</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —					16. SOCIAL SECURITY NO. —		17. INFORMANT <u>Mr Cooke</u>			ADDRESS <u>3006 Oakcrest Ave</u>	
18. <u>763.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>White hemorrhagic Branchopneumonia</u> <u>Respiratory ARREST.</u> <u>Massive Aspiration.</u> <u>Possible Intestinal trauma</u>					CAUSE OF DEATH <u>White hemorrhagic Branchopneumonia</u> <u>Respiratory ARREST.</u> <u>Massive Aspiration.</u> <u>Possible Intestinal trauma</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Manual Jernig's</u>											
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> 19 <u>67</u> to <u>7-11</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-11</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Hector C. Rodriguez</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>7-11-67</u>			
23C. PHYSICIAN'S NAME (Type) <u>Hector C. Rodriguez</u>					23D. ADDRESS <u>Union Memorial Hospital</u>						
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>7/9/67</u>			24C. NAME OF CEMETERY or CREMATORY <u>Moulton</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 14 1967</u>			25B. NAME OF REGISTRAR <u>Robert S. Faldut</u>			25C. FUNERAL DIRECTOR <u>W. J. Ferguson</u>			ADDRESS <u>6067 Hayford Rd</u>		

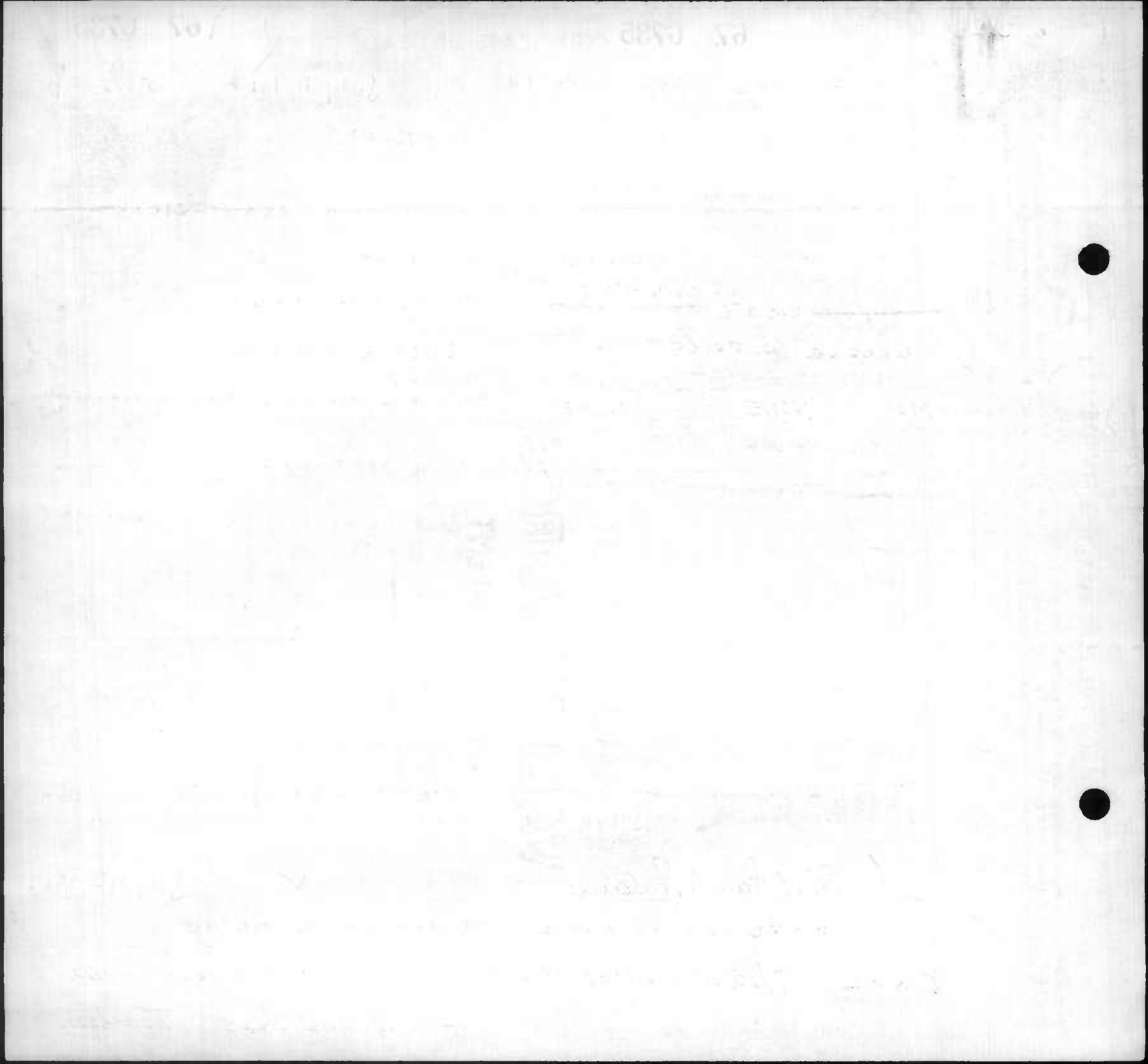
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
67. 6735 CERTIFICATE OF DEATH					Registered No. 67. 6735						
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) FRIEDEL, ANNA LORETTA</p> </div> <div> <p>2. DATE AND HOUR OF DEATH July 11, 1967 5:15 P.M.</p> </div> </div>											
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>The UNION MEMORIAL HOSPITAL</p>					<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY Bolts Co</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00</p> <p>D. STREET ADDRESS (If rural, give location) 2069 YORK ROAD 21093</p>						
<p>5. SEX Female</p>		<p>6. RACE WHITE</p>		<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED</p>		<p>8. DATE OF BIRTH 05-31-06</p>		<p>9. AGE (In years last birthday) 61</p>		<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed HWS. WFE.</p>					<p>10B. KIND OF BUSINESS OR INDUSTRY OWN HOME SUB-CONTRACTOR</p>		<p>11. BIRTHPLACE (State or foreign country) TEXAS, MARYLAND</p>			<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME GEORGE W. PRICE</p>					<p>14. MOTHER'S MAIDEN NAME LOTTIE COUGLE</p>						
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>					<p>16. SOCIAL SECURITY NO. NONE</p>		<p>17. INFORMANT ADDRESS FRIEDEL, MR LOUIS 2069 YORK ROAD - TIMONIUM MD</p>				
<p>18. 43411 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>(A) ACUTE PULMONARY EDEMA DUE TO</p> <p>ANTECEDENT CAUSES</p> <p>(B) CONGESTIVE HEART FAILURE DUE TO</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(C)</p>										<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>2 hours</p> <p>3 MONTHS?</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>											
<p>19A. DATE OF OPERATION</p>				<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>				<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>				<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>				<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>				<p>21E. INJURY OCCURRED</p> <p>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>				<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from July 11th 1967 to July 11th 1967, that (I) (we) last saw the deceased alive on July 11th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>											
<p>23A. SIGNATURE Miguel Sanchez-Palacios M.D.</p>								<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/></p>		<p>23B. DATE SIGNED July 11th, 1967</p>	
<p>23C. PHYSICIAN'S NAME (Type) MIGUEL SANCHEZ-PALACIOS M.D.</p>								<p>23D. ADDRESS THE UNION MEMORIAL HOSPITAL</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>		<p>24B. DATE 7/15/67</p>		<p>24C. NAME OF CEMETERY or CREMATORY DULANEY VALLEY MEMORIAL</p>				<p>24D. LOCATION (City, town, or county) (State) CORKEYSVILLE MD.</p>			
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967</p>				<p>25B. NAME OF REGISTRAR Robt E. Finkbeiner</p>				<p>25C. FUNERAL DIRECTOR ADDRESS JOHN BURNS SONS TOWSON.</p>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. C-615		67. 6736		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67. 6736	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) RUBY M. CARPENTER				7/10/67 1:05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 311 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND				A. STATE MD B. COUNTY			
5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLOOR LADY				D. STREET ADDRESS (If rural, give location) 236 So EATON ST.			
10B. KIND OF BUSINESS OR INDUSTRY PLASTICS				8. DATE OF BIRTH 6-20-09 9. AGE (In years last birthday) 60			
11. BIRTHPLACE (State or foreign country) RUBY, VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MILLARD FAIRCLOTH				14. MOTHER'S MAIDEN NAME DELLA SEXTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 244-24-1466			
17. INFORMANT RECORDS: BCH 4940 EASTERN AVENUE, BALTO. 21224, MD.				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) respiratory arrest				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. pulmonary congestion				< 3 mos.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Metastatic Carcinoma of Breast				3 yrs.			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 24 19 67 to July 10 19 67 , that (I) (we) last saw the deceased alive on JULY 10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joel Thurm M.D.				23B. DATE SIGNED 7/10/67			
23C. PHYSICIAN'S NAME (Type) DR. JOEL THURM M.D.				23D. ADDRESS 4940 EASTERN AVENUE, BALTO. 21224, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 7-13-67			
24C. NAME OF CEMETERY or CREMATORY DUBLIN SOUTHERN				24D. LOCATION (City, town, or county) DUBLIN, HARFORD CO., MD.			
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967				25B. NAME OF REGISTRAR John E. Fairbank, DELTA, PA.			
25C. FUNERAL DIRECTOR John E. Fairbank, DELTA, PA.				ADDRESS			

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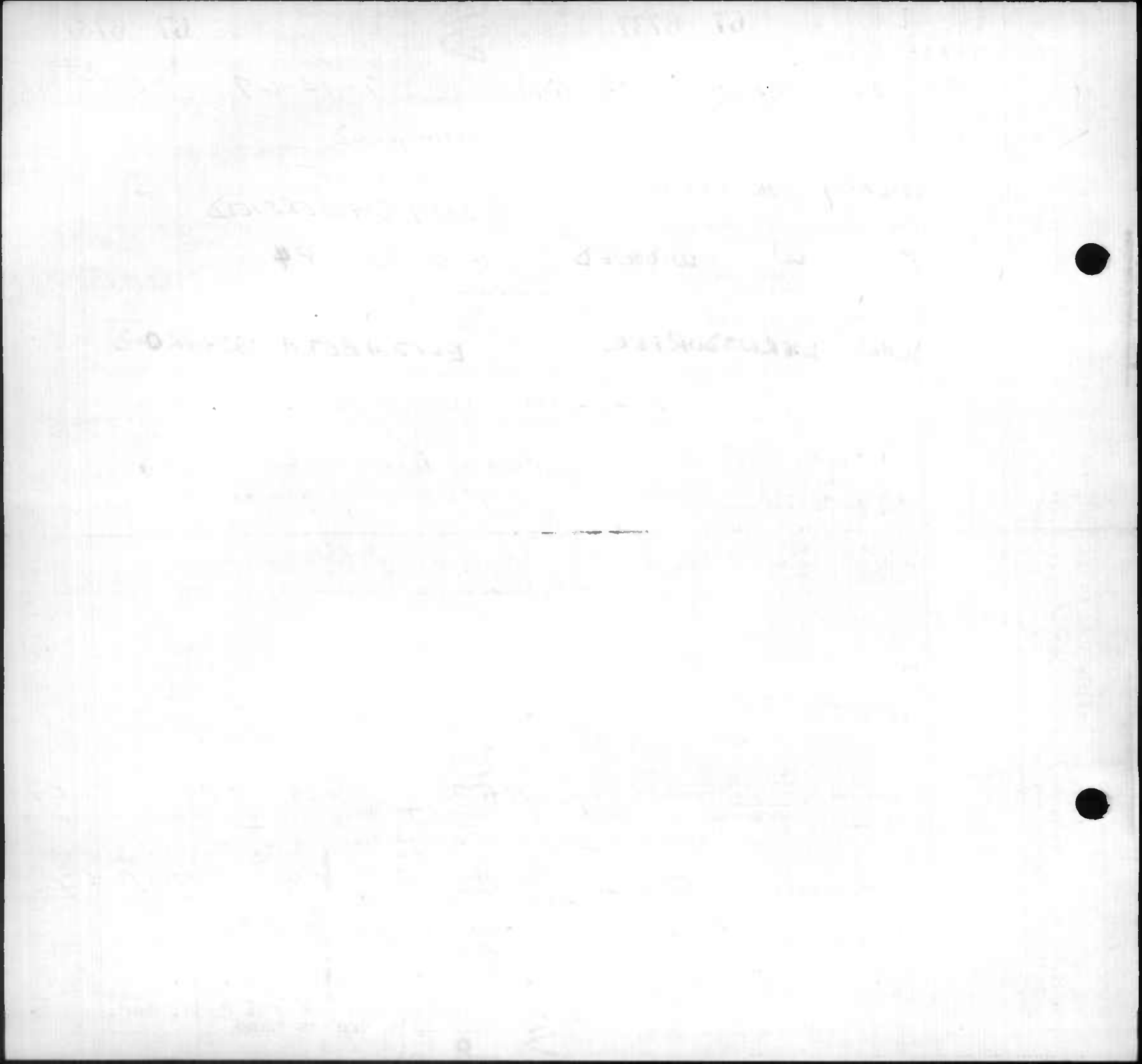
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6737	
BIRTH NO. 67 6737				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) ELIZABETH M. MOQUINN				2. DATE AND HOUR OF DEATH 7-13-67 5:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 3137 CHESTERFIELD	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-12-83	9. AGE (In years last birthday) 34	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME JOHN WERNSDORFER				12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME ELIZABETH SCHAROLD					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-54-3909		17. INFORMANT ADDRESS Elizabeth Bauer, dght. above	
18. 420.1 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) CVA - thrombosis DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 year
ANTECEDENT CAUSES			(B) 2° Coronary artery disease DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) rheumatoid arthritis, severe, dehydration, anemia		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-4 19 66 to 7-13 19 67 , that (I) (we) last saw the deceased alive on 7-13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Maria Y. Que				23B. DATE SIGNED 7-13-67	
23C. PHYSICIAN'S NAME (Type) MARIA Y. QUE		23D. ADDRESS M.D. MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/67		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Ad. B. Talma		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6738				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6738	
M.E. CASE NO.				OR			
1. NAME OF DECEASED (Type or Print)				MRS. FRANCES CRIST- Giancristoforo		2. DATE AND HOUR OF DEATH 7/11/67 7:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				1405 BANK STREET #31			
CHURCH HOME AND HOSPITAL 100 NORTH BROADWAY BALTIMORE, MARYLAND 21231				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND 21231			
D. STREET ADDRESS (If rural, give location)				3-01			
5. SEX 7	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/20/1897	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANTHONY DELLA VIOLA				14. MOTHER'S MAIDEN NAME MARY BACCALA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT ADDRESS Joseph Crist-husband, above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				19. BASE OF DEATH INTERVAL BETWEEN ONSET AND DEATH Atherosclerotic Cardio-Vascular Disease with Diabetes Left Main Artery Occlusion Heart Failure			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 6-25-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Left Main Artery Occlusion		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-25-1967 to 7-11-1967, that (I) (we) last saw the deceased alive on 7-11-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-11-67	
23C. PHYSICIAN'S NAME (Type) Dr. I. Anderson		23D. ADDRESS Clt & A					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/67		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Schimmek Funeral Home 3331 Brehm Lane #13		ADDRESS	

Chlorophyll *Chlorophyll*
Bromine and Chloride
left the (very common)

Heart Failure

1-27-07 left the (very common) the

4-11-07 10-11-07

Dr. I. Anderson
10-11-07

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6739	
BIRTH NO. 67 6739		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRANK BERNAT		2. DATE AND HOUR OF DEATH 7-10-67 11:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home & Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 21205 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 728 N. Linwood			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED , DIVORCED (specify)	8. DATE OF BIRTH 7/14/74	9. AGE (In years last birthday) 92	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Harford Tailoring Co		11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA	
13. FATHER'S NAME JACOB BERNAT		14. MOTHER'S MAIDEN NAME AMERICA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-03-6210A		17. INFORMANT ADDRESS Miss Helen Bernat, dght. above	
18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia, bilat.		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH few days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Generalized Arteriosclerosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 9 1967 to July 10 1967 , that (I) (we) last saw the deceased alive on July 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodolfo M. Lim M.D.				23B. DATE SIGNED 7-10-67	
23C. PHYSICIAN'S NAME (Type) Rodolfo M. Lim M.D.				23D. ADDRESS CHH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/67		24C. NAME OF CEMETERY or CREMATORY Bohemian National Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECORDED IN HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.	

JACOB BERNAT

M W
Church Home - 100
1114 1/2 St
1114 1/2 St

GEORGE L. O'NEIL

1114 1/2 St

1114 1/2 St

1114 1/2 St
1114 1/2 St

1114 1/2 St

1114 1/2 St
1114 1/2 St

1114 1/2 St

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6740		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6740	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LLOYD ADOLPHUS MILBURN		7-12-67 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE			
2319 ASHLAND AVE.		MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		2319 ASHLAND AVE.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
M	W.	MARRIED.	9-1-1902	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MAILMAN		Post Office		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
ROBERT M. MILBURN			GERTRUDE EMMA HEWITT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216 07 9585		Mrs. Evelyn A. Milburn - 2319 Ashland Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		few minutes	
ANTECEDENT CAUSES		(B) DUE TO		2 1/2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		several years	
		Coronary occlusion			
		Chr. Heart Failure			
		Generalized arteriosclerosis			
		Senile emphysema, severe		several years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 19 1965 to July 5 1967 , that (I) was last saw the deceased alive on July 5 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Eugene C. Baumann				7/14/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
EUGENE C. BAUMANN		413 EASTERN AVE, Baltimore 21, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		7-15-67		BALTIMORE Cem.	
				24D. LOCATION (City, town, or county) (State)	
				BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 14 1967		Robert E. Baumann		2334 Jefferson St.	

2000 1000 1000

1000 1000

1000 1000

1
R-300

67 6741

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6741

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VINCENT L. RUTH

2. DATE AND HOUR PRONOUNCED DEAD

July 11, 1967 19:47 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)35
99 CHURCH HOME AND HOSPITAL D.O.A.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2122 E. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

1-23-1920

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MILLMAN

10B. KIND OF BUSINESS OR INDUSTRY

RUBBER IND.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY RUTH

14. MOTHER'S MAIDEN NAME

CATHERINE DECKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-01-1449

17. INFORMANT

ADDRESS

Mrs. Mary A. Ruth - 801 N. Madenia St.

18.

581.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive gastro-intestinal
DUE TO hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Marked cirrhosis
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher

M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-14-67

23C. NAME OF CEMETERY OR CREMATORY

GARDEN OF FAITH CEM.

23D. LOCATION

(City, town, or county)

BALTO. MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 14 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Spill, Miller - 2334 Jefferson St.

ADDRESS

1-2-1920

1-2-1920
Rosen for
Clemens Jones

Received the sum of \$10.00

Wm. C. Jones
Rosen for
Clemens Jones
1-2-1920

Wm. C. Jones
Rosen for
Clemens Jones

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6742	
BIRTH NO. 67 6742		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GREEN, William		2. DATE AND HOUR OF DEATH 7-12-67 7:30 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION DukeLand Nursing Home 1501 N. DukeLand St.		A. STATE Baltimore B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-47 D. STREET ADDRESS (If rural, give location) 2225 Koko Lane			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-06-76	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-9350		17. INFORMANT Margaret Gilliard ADDRESS 2225 Koko Lane	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE (B) GENERALIZED ARTERIO SCLEROSIS (C)			
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-5 1967 to 7-12 1967 , that (I) (we) last saw the deceased alive on 7-12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas W. Harris M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) THOMAS W. HARRIS				23D. ADDRESS M.D. 1824 W. FRANKLIN ST	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/67		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem	
24D. LOCATION (City, town, or county) (State) Balto. Md		25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967			
25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR Earl Schmore ADDRESS 1827 W. North Ave			

01 0000

05 0000

10-10-10 11:00 AM

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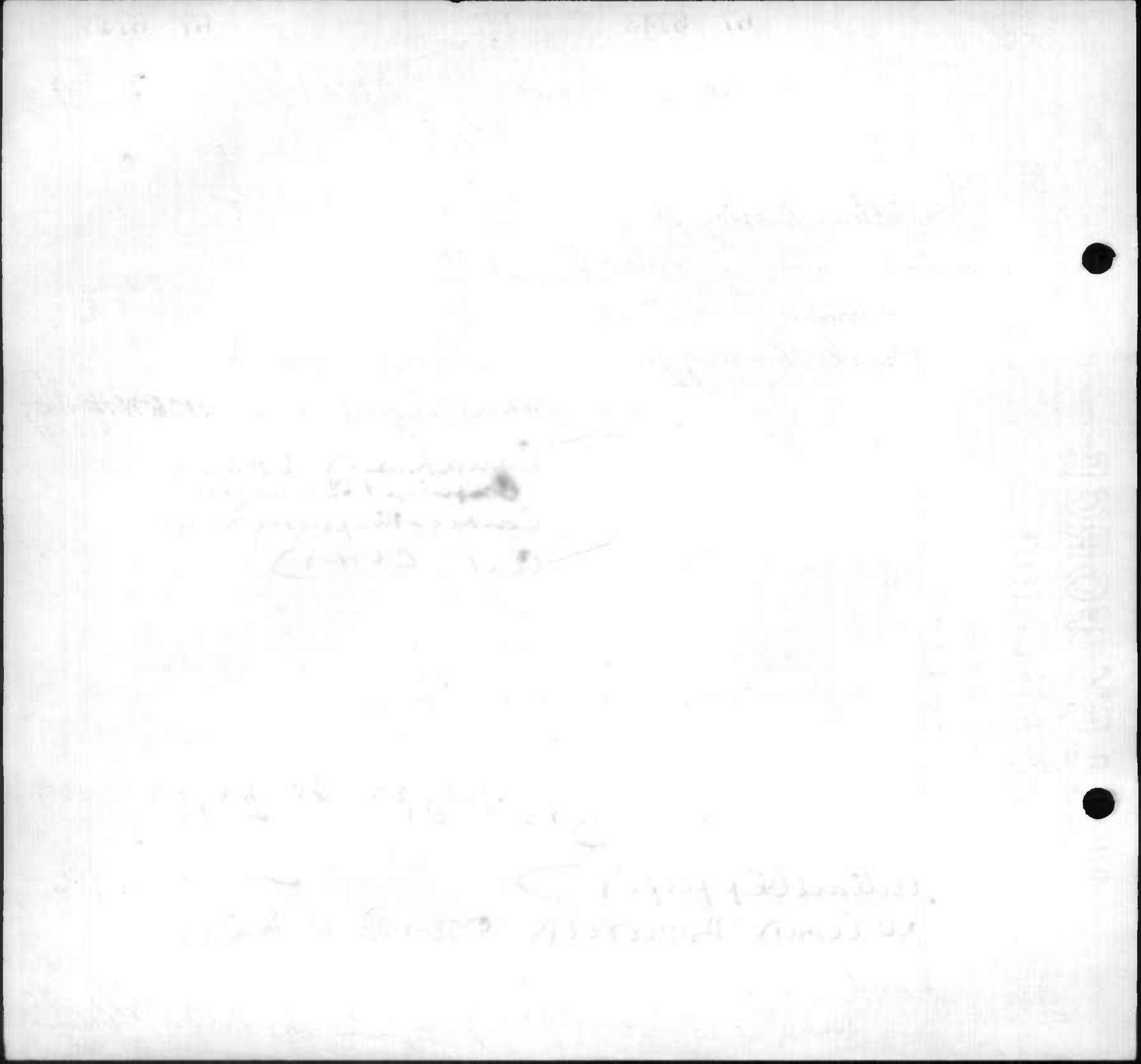
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FUNERAL DIRECTOR: IMPORTANT

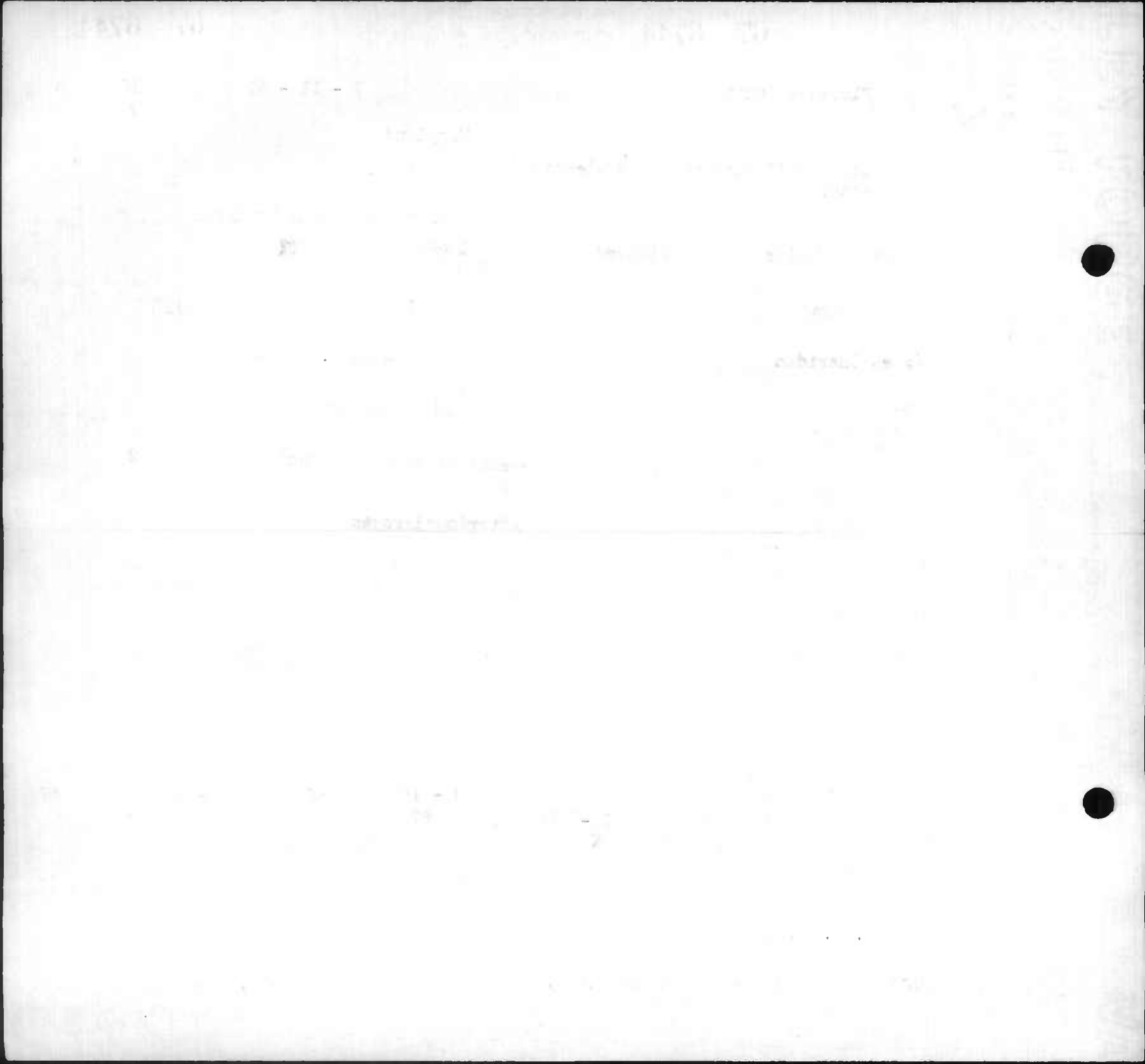
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6743				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6743			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <i>Marie De Marco</i>				2. DATE AND HOUR OF DEATH <i>7/13/67</i> <i>2:55</i> A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <i>Midtown Nursing Home</i>				A. STATE <i>MD</i>				B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				D. STREET ADDRESS (If rural, give location) <i>808 St. Paul St.</i>			
5. SEX <i>Female</i>		6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>5/23/1897</i>		9. AGE (In years last birthday) <i>70</i>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Charwoman</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>				11. BIRTHPLACE (State or foreign country) <i>MD</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				13. FATHER'S NAME <i>Frank Carnaggio</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Scalco</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>✓</i>				16. SOCIAL SECURITY NO. <i>214-145582</i>				17. INFORMANT <i>Mrs Margaret Hahn Miller</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>174X1</i>				CAUSE OF DEATH (A) <i>Complications of Ulcers</i> DUE TO <i>Chronic Gastritis</i> (B) <i>Cardio-Respiratory Failure</i> DUE TO (C) <i>ant CUHD</i>				ADDRESS <i>1126 W. Hubbard St.</i> INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>No</i>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>July 27 1965</i> to <i>July 13 1967</i> , that (I) (we) last saw the deceased alive on <i>July 13 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.											
23A. SIGNATURE <i>Willard Appleper</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>7/13/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>Willard Appleper</i>				23D. ADDRESS <i>5507 Park Heights Rd.</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>7/17/67</i>				24C. NAME OF CEMETERY OR CREMATORY <i>Nor Cathedral Cem.</i>			
24D. LOCATION (City, town, or county) (State) <i>4300 Old Frederick Rd. Md.</i>											
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 14 1967</i>				25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>				25C. FUNERAL DIRECTOR <i>John J. Curran & Son Inc.</i>			
								ADDRESS <i>987 Hollins St. Md.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6744 CERTIFICATE OF DEATH					Registered No. 67 6744				
1. NAME OF DECEASED (Type or Print) Florence Keatts					2. DATE AND HOUR OF DEATH 7 - 11 - 67 10 p.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bolton Hill Nursing & Convalescent Center					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Layfatte & John Sts.				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Jan 21 1893	9. AGE (In years lost birth) 74	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at Home			10B. KIND OF BUSINESS OR INDUSTRY		11. PLACE OF BIRTH (State & foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Sheridan			14. MOTHER'S MAIDEN NAME Sarah T. Wells			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.			17. INFORMANT Family Records			ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident					INTERVAL BETWEEN ONSET AND DEATH 2				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4 - 15 19 66 to 7 - 11 19 67 , that (I) (we) last saw the deceased alive on 7 - 11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (I) (did) (did not) view the body after death.									
23A. SIGNATURE L. A. Lally					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 11, 1967		
23C. PHYSICIAN'S NAME (Type) L. A. Lally					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/67		24C. NAME OF CEMETERY or CREMATORY Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR G. F. Evans, Son		ADDRESS 8812 Hanford Rd			



W-452

67 6745 BALTIMORE CITY HEALTH DEPARTMENT MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6745

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LLEWELYN J. WILLIAMS		2. DATE AND HOUR PRONOUNCED DEAD July 10, 1967 12:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3913 Falls Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3913 Falls Road	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 13, 1913
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10B. KIND OF BUSINESS OR INDUSTRY Golf Course	9. AGE (In years last birthday) 54
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME William Williams		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 96 01 6374	17. INFORMANT Audrey Williams
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 974X		CAUSE OF DEATH (A) Asphyxia DUE TO Hanging (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Cellar - 3913 Falls Road	13-07
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ?	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Hanged self	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE July 13, 1967	23C. NAME OF CEMETERY or CREMATORY Dulaney Valley
23D. LOCATION (City, town, or county) (State) Cockeysville, Maryland		24A. DATE REC'D BY HEALTH DEPT. JUL 14 1967	
24B. NAME OF REGISTRAR Robert E. Farkas, M.D.		24C. FUNERAL DIRECTOR Burgess Funeral Home	
		ADDRESS 3631 Falls Rd	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 6746	
BIRTH NO. 67 6746		CERTIFICATE OF DEATH		Registered No. 67 6746	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) THOMPSON MARY		2. DATE AND HOUR OF DEATH 7. 11. 67 3.35 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital		A. STATE MD		BALTIMORE 21217 15-01	
6. SEX Female		7. RACE COLORED		8. DATE OF BIRTH 8.30.86	
9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED		10. AGE (In years last birthday) 80		11. BIRTHPLACE (State or foreign country) MD.	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. KIND OF BUSINESS OR INDUSTRY		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Abraham Levi		16. MOTHER'S MAIDEN NAME Millie Green		17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
18. SOCIAL SECURITY NO. 214563571		19. INFORMANT MARIE WADE		ADDRESS 3512 ARUNAH AVE.	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH C.V.A.		INTERVAL BETWEEN ONSET AND DEATH 13 days	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO A.S.H.C.V.D.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6.29.1967 to 7.11.1967 that (I) (we) last saw the deceased alive on 6.10.67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nicholas Radujkovic		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7.11.67	
23C. PHYSICIAN'S NAME (Type) MIKOS RADOJKOVIC		23D. ADDRESS M.D. LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-67		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION BALTO., Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6747</u>	
BIRTH NO. <u>67 6747</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Robert Thompson</u>		2. DATE AND HOUR OF DEATH <u>July 13, 1967</u> <u>5:15 a. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>39</u> <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>15-01</u> D. STREET ADDRESS (If rural, give location) <u>1347 N. Stricker Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 1, 1921</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>226207980</u>		17. INFORMANT <u>Willie Lee Thompson-brother</u>		ADDRESS <u>same</u>	
18. <u>757.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Polycystic kidney</u> DUE TO		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Antecedent causes</u> <u>Bronchopneumonia & pulmonary edema</u> <u>Congenital cysts of liver</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1967</u> to <u>July 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 13, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>July 13, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Captain I. Land</u>		23D. ADDRESS M.D. <u>1514 Division Street-Baltimore, Maryland(17)</u>			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <u>Burial</u> <u>7-16-67</u>		24C. NAME of CEMETERY or CREMATORY <u>First Union Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Goochland County, Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Kelson Funeral Home 2348 Calhoun St.</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67. 6748		67. 6748		67. 6748	
M.E. CASE NO.		CERTIFICATE OF DEATH		7/11/67	
1. NAME OF DECEASED (Type or Print) MARGARET GIBSON		2. DATE AND HOUR OF DEATH 7/11/67		6:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Lincoln Nursing Home		A. STATE 312 N Pine Street		B. COUNTY Balt. Md	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4-02			
		D. STREET ADDRESS (If rural, give location) 312 N Pine Street			
5. SEX F	6. RACE N N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3-27-1902	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME Jack Stewart		14. MOTHER'S MAIDEN NAME Louisa Stewart		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Nancy Albright,	
				ADDRESS 22 S Carlton St	
18. I 175.0 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) OVARIAN CARCINOMA		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/11/67 19 to 7/11/67 19, that (I) (we) last saw the deceased alive on 7/11/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hollis Steunarine		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/11/67	
23C. PHYSICIAN'S NAME (Type) HOLLIS STEUNARINE		23D. ADDRESS 5519 KENNISOD AVENUE BALI, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR 1206 W North Ave	
				ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6749	
67 6749				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		BOWEN, ROBERT J.		JULY 10, 1967 2:20P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY	
D. STREET ADDRESS (If rural, give location) 169 CHATHAM RD. 21043		E. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY		F. STREET ADDRESS (If rural, give location) 169 CHATHAM RD. 21043	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10/15/84 1880	9. AGE (In years last birthday) 82 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-14-5433		17. INFORMANT Robert B. Bowen-169 Chatham Rd. - 21043 ST. AGNES HOSPITAL RECORDS	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Myocardial Infarction recent, post. septal (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 4, 1967 19 to JULY 10 1967, that (I) (we) last saw the deceased alive on JULY 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Vasallo				23B. DATE SIGNED 7-10-67	
23C. PHYSICIAN'S NAME (Type) Paulino O. Vasallo				23D. ADDRESS M.D. ST. AGNES HOSP; CATON & WILKENS AVES XXXXX	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/67		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 14 1967		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		24H. ADDRESS Witzke F. D. - 4101 Edmondson Ave.		24I. ADDRESS Witzke F. D. - 4101 Edmondson Ave.	

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ST. AGNES HOSPITAL

JULY 10, 1967

MARYLAND

ST. AGNES HOSPITAL

155 CHATAM DR., STONE

WIDOWED WHITE

10/12/32

RETIRED

MARYLAND

UNKNOWN

VIRGINIA

ST. AGNES HOSPITAL RECORDS

JULY 10

JULY 10, 1967

JULY 10

ST. AGNES HOSPITAL RECORDS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6750		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6750	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		CATHERINE PINKNEY		2. DATE AND HOUR OF DEATH 7-5-67 6:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		10-02	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
33 THE JOHNS HOPKINS HOSPITAL		BALTIMORE		D. STREET ADDRESS (If rural, give location)	
		919 E. MADISON ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
FEMALE	NEGROID	SINGLE	12-27-19	47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JAMES E. PINKNEY		ELLA HEAVEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Hospital Friends	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		20 DAYS	
ANTECEDENT CAUSES		(B) DUE TO		16 DAYS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		DEBILITATION		?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 15, 1967 to JULY 5, 1967, that (I) (XX) last saw the deceased alive on JULY 5, 1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
JOHN V. RUSSO		7-5-67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
John V. Russo		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		July 13, 1967		Mt. Calvary Cemetery Brooklyn Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 14 1967		Robert E. Fairburn		Joseph L. Russo 2222 W. North Ave. Baltimore, Md.	

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67. 6751 BALTIMORE CITY HEALTH DEPARTMENT 67. 6751

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WILLIAM SPRIGGS 2. DATE AND HOUR PRONOUNCED DEAD July 9, 1967 8:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

CERTIFICATE AMENDED

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH Jan 6-39 9. AGE (In years last birthday) 28 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 11. KIND OF BUSINESS OR INDUSTRY Baltimore 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME Major Spriggs 14. MOTHER'S MAIDEN NAME Bertha Short 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). If yes, give war or dates of service 16. SOCIAL SECURITY NO. 17. INFORMANT Claudett Spragg 1821 Mc Kean AVE

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Drowning (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute ethylism

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) water 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Wagner's Point - Curtis Bay 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7-9-67 4:50 P.M. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? Row-boat overturned

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ CHIEF MEDICAL EXAMINER ☐ DATE SIGNED July 10, 1967

ACTUAL SIGNATURE Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER ☒ EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 7-13-67 23C. NAME OF CEMETERY OR CREMATORY Mt Calvary Em. C. & Co 23D. LOCATION (City, town, or county) (State) Md

24A. DATE REC'D BY HEALTH DEPT. JUL 14 1967 24B. NAME OF REGISTRAR Robert E. Taylor, Md 24C. FUNERAL DIRECTOR Rayner Sanders 217 E. Preston St

VS 151-REV. 1/1/65

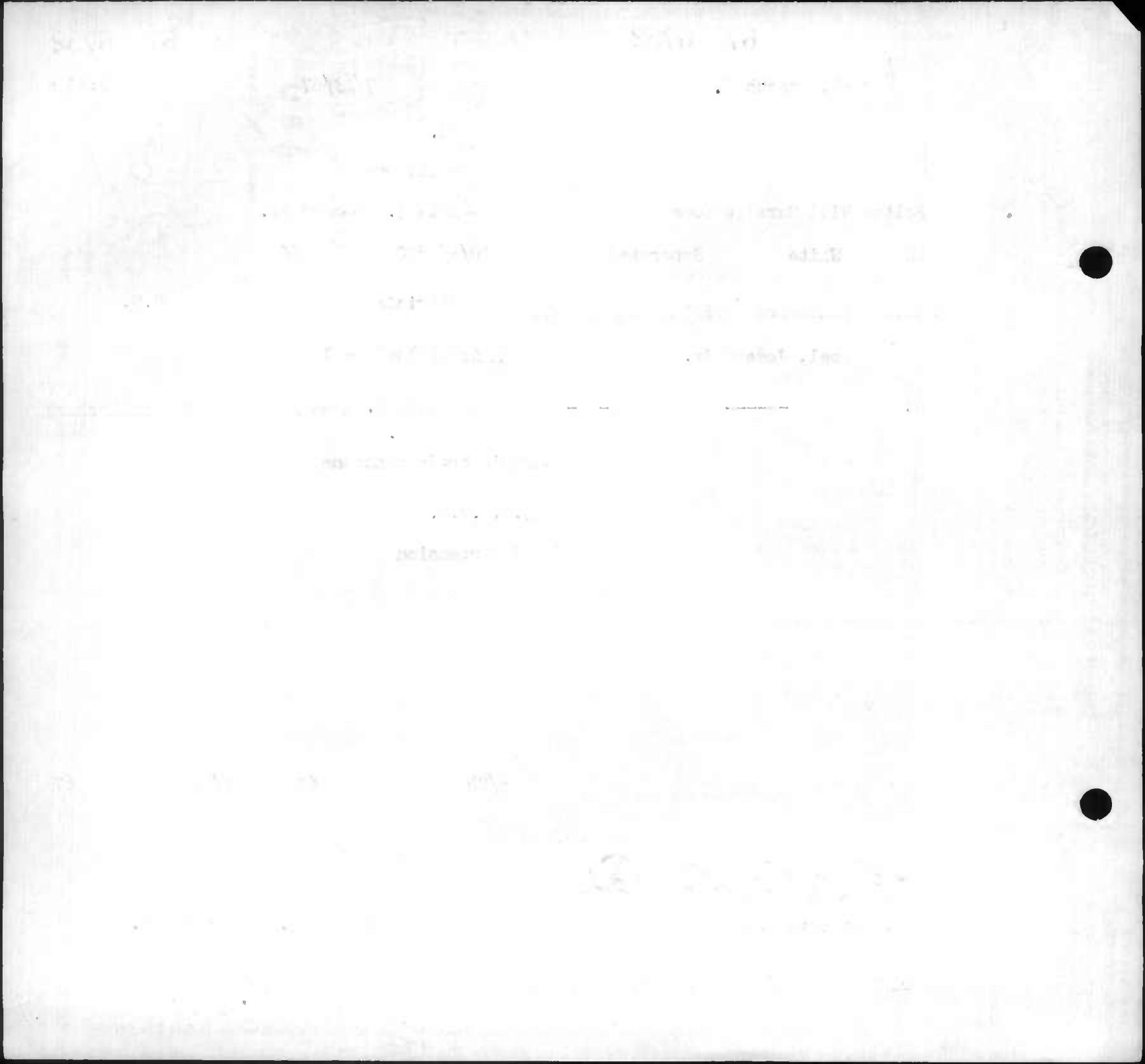
Letter from M.E.'s Office

7-19-67

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67. 6752 CERTIFICATE OF DEATH					Registered No. 854 67 6752				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Abel, Joseph V.					2. DATE AND HOUR OF DEATH 7/13/67 2:30 a.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bolton Hill Nursing Home					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1915 E. Lombard St.				
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED Separated	8. DATE OF BIRTH 10/5/1880	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance			10B. KIND OF BUSINESS OR INDUSTRY Balto City Pumping		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Abel, Joseph Sr.					14. MOTHER'S MAIDEN NAME Annie Matilda Douglas				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-46-8524		17. INFORMANT Elizabeth O. Abel 369 Boyd Ave Martinsberg W Va				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Chronic brain syndrome ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.C.V.D. Hypertension					CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 5/24 19 67 to 7/14 19 67 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E. Elsworth Cook M.D.					23B. DATE SIGNED			23C. PHYSICIAN'S NAME (Type) E. Elsworth Cook M.D.	
23D. ADDRESS 2431 Maryland Ave. Baltimore Md.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 15 67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) 4430 Belair Road Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Angel Bros INC.		25D. ADDRESS 1800 E. Lombard St			



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K-536

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6753

1. NAME OF DECEASED
(Type or Print)

HENRY KANTORSKI

2. DATE AND HOUR PRONOUNCED DEAD

July 13, 1967

8:35 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home & Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Pennsylvania

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Philadelphia

D. STREET ADDRESS (If rural, give location)

U.S. Naval Home

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

Nov 3 1909

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work)

Retired B T G I

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Navy Pumping

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland.

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

James Kantorski

14. MOTHER'S MAIDEN NAME

Mary Kaminska

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World II

16. SOCIAL
SECURITY NO.

213-28-9308

17. INFORMANT

ADDRESS

Pricilla Rachuba 2542 Fleet Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

July 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 17 1967

23C. NAME of CEMETERY or CREMATORY

Balto National Cemetery

23D. LOCATION

(City, town, or county)

Frederick Road

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 14 1967

Robert E. Farkas, M.D.

The Dippel Brothers Inc 1800 E Lombard St

MAILED 10 10 1967

10 10 1967

10 10 1967

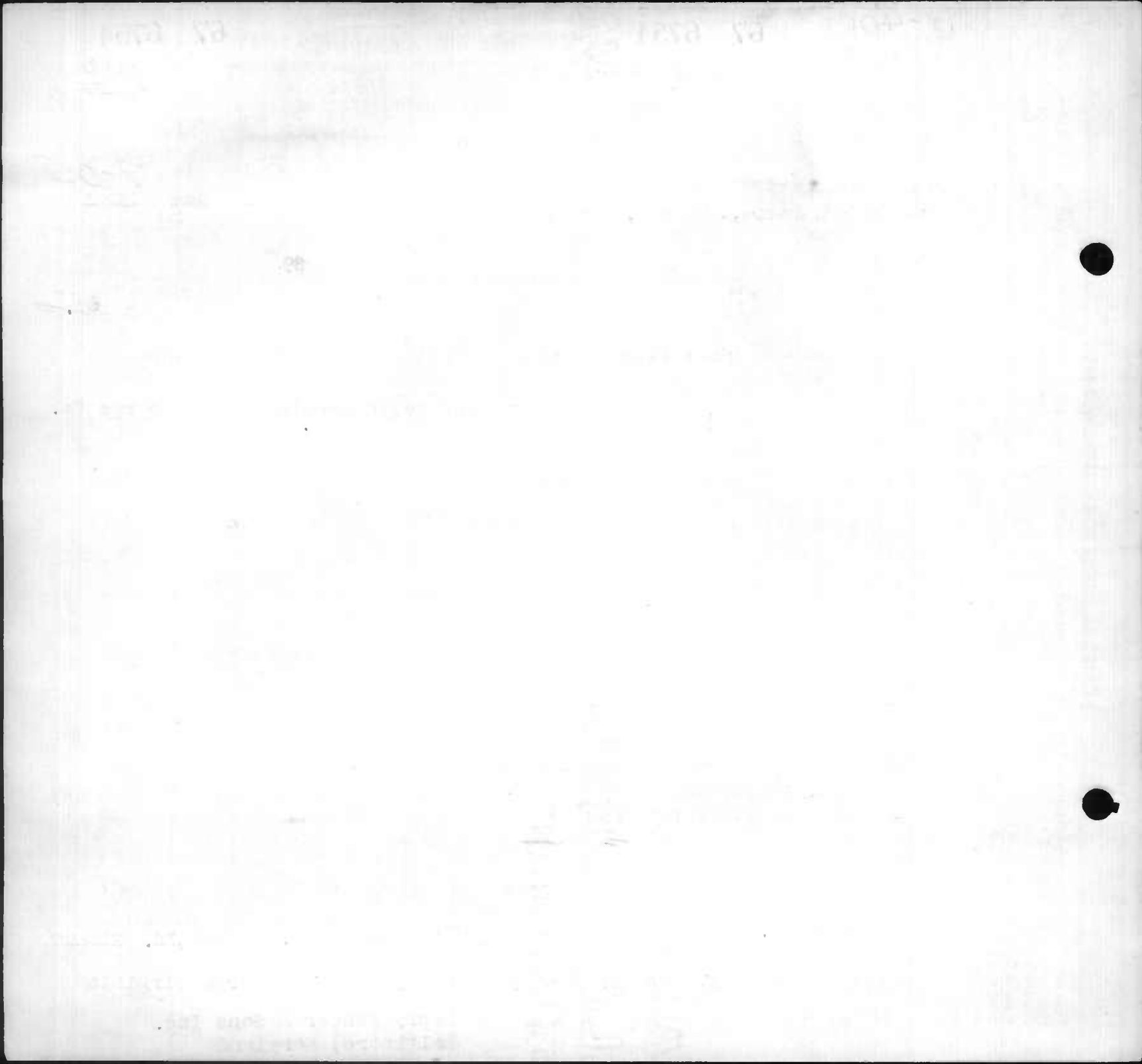
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10 10 1967

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400		67. 6754		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67. 6754	
BIRTH NO.							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) SARAH HALL Sarah Frances Hall				2. DATE AND HOUR OF DEATH 7/8/67 8:40 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Maryland				A. STATE MD B. COUNTY BALTIMORE, Md. 7-05			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If not, give location)			
BALTIMORE, Md.				4940 Eastern Avenue 21224 512 N. CHESTER ST.			
5. SEX Female	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9/10/77	9. AGE (In years) 89 YRS	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEVER HAD A JOB		11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U.S. - A.			13. FATHER'S NAME UNKNOWN James Henry Morgan		14. MOTHER'S MAIDEN NAME UNKNOWN Fenton Combs		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 216-54-4653T		17. INFORMANT Mrs Zella Bradley King, George Va.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARCINOMA (R) BREAST (B) PULMONARY TUBERCULOSIS (C) _____ INTERVAL BETWEEN ONSET AND DEATH 10 YRS 7 YRS				19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				21. MEDICAL CERTIFICATION			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. DATE SIGNED 7/8/67		21H. PHYSICIAN'S NAME (Type) Michael R. McMillan	
22. I certify that (this hospital) attended the deceased from MARCH 18 1960 to JULY 8 1967, that (we) last saw the deceased alive on JULY 8 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.				23. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/67		24C. NAME OF CEMETERY or CREMATORY Morgan Family Cemetery		24D. LOCATION (City, town, or county) (State) King George Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Robert E. Faulkner		25C. FUNERAL DIRECTOR Henry Sander & Sons Inc.		ADDRESS Baltimore, Maryland	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67. 6755		CERTIFICATE OF DEATH		67 6755	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>ROSA FROCHLIE BLADES</u>			2. DATE AND HOUR OF DEATH <u>7/11 1967</u> <u>5:30 A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp</u>			A. STATE <u>Md.</u> B. COUNTY <u>Baltimore City</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21218</u> <u>9-06</u>		
			D. STREET ADDRESS (If rural, give location) <u>1721 East 32nd St</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. <u>MARRIED</u> NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>8/02/01</u>	9. AGE (In years last birthday) <u>65</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>August Frochlie</u>			14. MOTHER'S MAIDEN NAME <u>Anna — ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>214-165202A</u>		
			17. INFORMANT ADDRESS <u>Milton D. Blades (husband)</u> <u>1721 E. 32nd St. Baltimore Md. 21218</u>		
18. <u>410 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Cardiac Arrest</u> DUE TO (B) <u>Congestive Heart Failure</u> DUE TO (C) <u>Mitral Stenosis</u>		
INTERVAL BETWEEN ONSET AND DEATH					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>6/12</u> 19 <u>67</u> to <u>7/11</u> 19 <u>67</u> that (I) <u>we</u> last saw the deceased alive on <u>7/11</u> 19 <u>67</u> and that (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above <u>(I) (we) (did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>B. J. Weckesser</u>					23B. DATE SIGNED <u>7/14/67</u>
23C. PHYSICIAN'S NAME (Type) <u>BARRY J. WECKESSER,</u>					23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
<u>Burial</u>		<u>July 15, 1967</u>	<u>Woodlawn Cemetery</u>		<u>Baltimore Md.</u>
25A. DATE REC'D BY HEALTH DEPT.			25C. FUNERAL DIRECTOR ADDRESS		
<u>JUL 14 1967</u>			<u>HENRY SANDER & SONS, INC.</u> <u>Baltimore Md.</u>		

LA JOLLA, CALIFORNIA

THE UNION MEMORIAL HOSPITAL

of Western

July 1911

July 1911

July 1911

July 1911

No

Progressive Heart Failure
Pulmonary Stenosis

(cardiac arrest)

8-15-1911

August Froeschle

Anna -

Germany

8/20/01

W

F

Glenn Memorial Hosp
1701 Fort Street

1701 Fort Street

Glenn Memorial Hosp

07 0100

07 0100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6756	
BIRTH NO. 67 6756		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALBERT DOENGES			
2. DATE AND HOUR OF DEATH 13 July 1967 1 8 P					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL 5 BALTIMORE, MD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD 6-03			
		D. STREET ADDRESS (If rural, give location) 2106 E. FAYETTE ST			
5. SEX M	6. RACE CAUC	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-9-92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rock Paper		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Friedrich J. Doenges		14. MOTHER'S MAIDEN NAME Elizabeth Urban	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-094548		17. INFORMANT Mrs. Catherine M. Doenges	
18. 332X1		CAUSE OF DEATH		ADDRESS 2106 E. Fayette St	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) CEREBRAL Thrombosis DUE TO GENERALIZED ARTERIOSCLEROSIS ARTERIOSCLEROTIC Heart Disease Cerebral Artery Disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) generalized ARTERIOSCLEROSIS (C) Pulmonary Emphysema			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/11/1967 to 7/13/1967 , that (I) (we) last saw the deceased alive on 7/13/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco Baltazar		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/13/67	
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR		23D. ADDRESS CHURCH HOME & HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE July 17/67		24C. NAME OF CEMETERY or CREMATORY Garden of Faith	
24D. LOCATION (City, town, or county) (State) Baltimore					
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Johns Funeral Home	
				ADDRESS 1001	

Robert M.
Higdon, Jr.
The following is a list of the

Robert M. Higdon, Jr.
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6757	
67 6757				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VERNON HARTGE	
2. DATE AND HOUR OF DEATH 7/11/67		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF 42 BALTIMORE			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 28-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Maryland 21207			
D. STREET ADDRESS (If rural, give location) 2447 Pickwick Road					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH May 15, 1901	9. AGE (In years last birthday) 66	10. CITIZEN OF WHAT COUNTRY USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Building Service		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Harry F. Hartge			14. MOTHER'S MAIDEN NAME Bessie Heath		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 8-23-19; 5-18-20		17. INFORMANT Christine Hartge	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SEPTIC SHOCK		CAUSE OF DEATH (A) DUE TO ? PERFORATED VISCUS		INTERVAL BETWEEN ONSET AND DEATH 20 HRS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO MASSIVE GI HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 20 HRS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CIRRHOSIS OF THE LIVER				INTERVAL BETWEEN ONSET AND DEATH MANY YEARS	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/11 19 60 to 7/11 19 67 , that (1) (we) last saw the deceased alive on 7/11 19 67 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. R. Shochet, M.D.				23B. DATE SIGNED 7/11/67	
23C. PHYSICIAN'S NAME (Type) BERNARD R. SHOCHET, M.D.				23D. ADDRESS 6804 PARK HEIGHTS AVE #15	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ellsworth Armacost, 4600 Liberty Heights			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-652		67. 6758		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6758	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Lucille ARMISTEAD		7/12/67 1:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 4940 EASTERN AVENUE. Baltimore City Hospital BALTIMORE 21224, MARYLAND				A. STATE 410 N. Avondale Rd Zone 22 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, M.D. 53-00 D. STREET ADDRESS (If rural, give location) 410 N. Avondale Rd.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-28-20	9. AGE (In years lost birthday) 47	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) wife.		
11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME George Brewer	
14. MOTHER'S MAIDEN NAME Henrietta Wym.			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH 4940 EASTERN AVE. BALTIMORE, MD.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) 593X14260X		CAUSE OF DEATH (A) Chronic Renal Failure (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		hypertension, diabetes					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 6/5/67 19 to 7/12/67 19 that (I) (we) last saw the deceased alive on 7/12/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francine Segal M.D.				23B. DATE SIGNED 7/12/67		23C. PHYSICIAN'S NAME (Type) FRANCINE SEGAL M.D.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-17-67		24C. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton E. Dyett F.H.		25D. ADDRESS 1701 Laurens St.	

My dear Sir,
I have the honor to acknowledge
the receipt of your letter of the
10th inst. in relation to the
subject of the
above mentioned
matter.

I have the honor to acknowledge
the receipt of your letter of the
10th inst. in relation to the
subject of the
above mentioned
matter.

I have the honor to acknowledge
the receipt of your letter of the
10th inst. in relation to the
subject of the
above mentioned
matter.

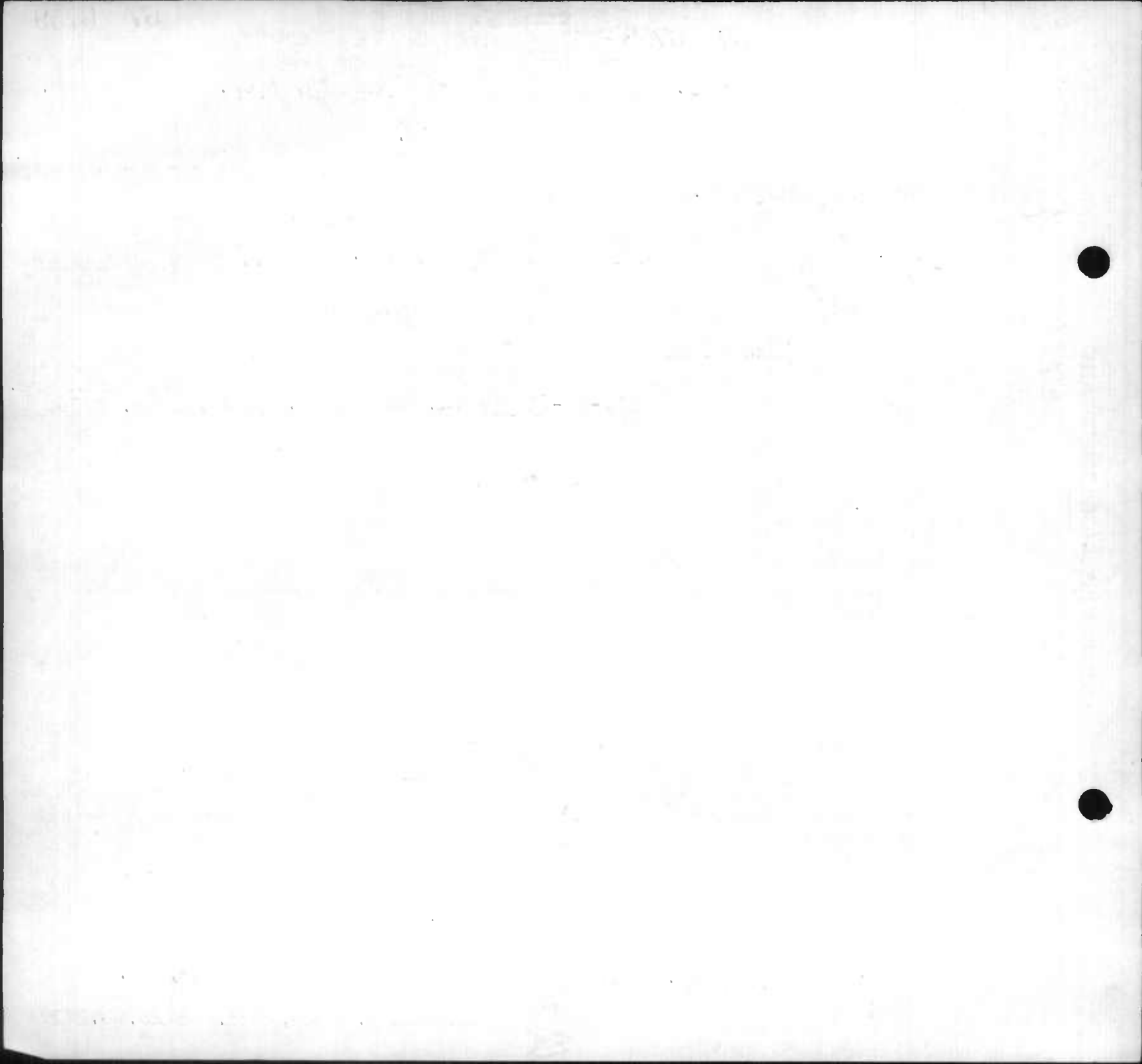
I have the honor to acknowledge
the receipt of your letter of the
10th inst. in relation to the
subject of the
above mentioned
matter.

Yours very truly,
Wm. H. Smith

Yours very truly,
Wm. H. Smith

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6759	
BIRTH NO. 67 6759					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Mary F. Eagan</i>			2. DATE AND HOUR OF DEATH <i>July 13, 1967. 6 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Harford Gardens Nursing Home</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		
5. SEX <i>Female</i>			6. RACE <i>White</i>		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>			8. DATE OF BIRTH <i>May 21, 1890.</i>		
9. AGE (In years last birthday) <i>77</i>			10. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John White</i>			14. MOTHER'S MAIDEN NAME <i>Barbara ?</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>220-44-651591</i>		
17. INFORMANT <i>Mr. William S. Eagan, Balto.</i>			ADDRESS <i>5926 Karon Ave. Balto. 21206</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>420.01</i>			CAUSE OF DEATH (A) <i>Arteriosclerotic Heart Disease</i> DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>3 year</i> DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <i>No</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. HOW DID INJURY OCCUR?		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from <i>Jan 1964</i> to <i>July 13 1967</i> , that (1) (we) last saw the deceased alive on <i>July 12 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert E. Levy</i>			23B. DATE SIGNED <i>7/13/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>Robert E. Levy</i>			23D. ADDRESS <i>114 Medical Art Bldg.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>7/17/67.</i>		
24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		
25A. DATE REC'D. BY HEALTH DEPT. <i>JUL 14 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. Levy, M.D.</i>		
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>			ADDRESS <i>Balto. Md. 21214</i>		



BIRTH NO. 67
M.E. CASE NO.

6760

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6760

1. NAME OF DECEASED
(Type or Print)

MAURICE B. SMITH

2. DATE AND HOUR PRONOUNCED DEAD

July 12, 1967

6:10 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
 44
 Union Memorial Hospital (DOA)
 7-25-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4608 Asbury Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

June 27, 1934
6/27/349. AGE (In years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Maurice B. Smith, Sr.

14. MOTHER'S MAIDEN NAME

Margaret T. Milbourne

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Maurice B. Smith, Sr. -- Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Shotgun wound of head

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4608 Asbury Avenue

21D. TIME
OF INJURY
(APPROX.)

7-12-67

(Month) (Day) (Year)

5:45 P.

(Hour)

m.

21E. INJURY OCCURRED
WHILE AT WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/15/67

23C. NAME OF CEMETERY or CREMATORY

Gardens of Faith Cem.

23D. LOCATION

(City, town, or county)

Baltimore Co.

Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 14 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

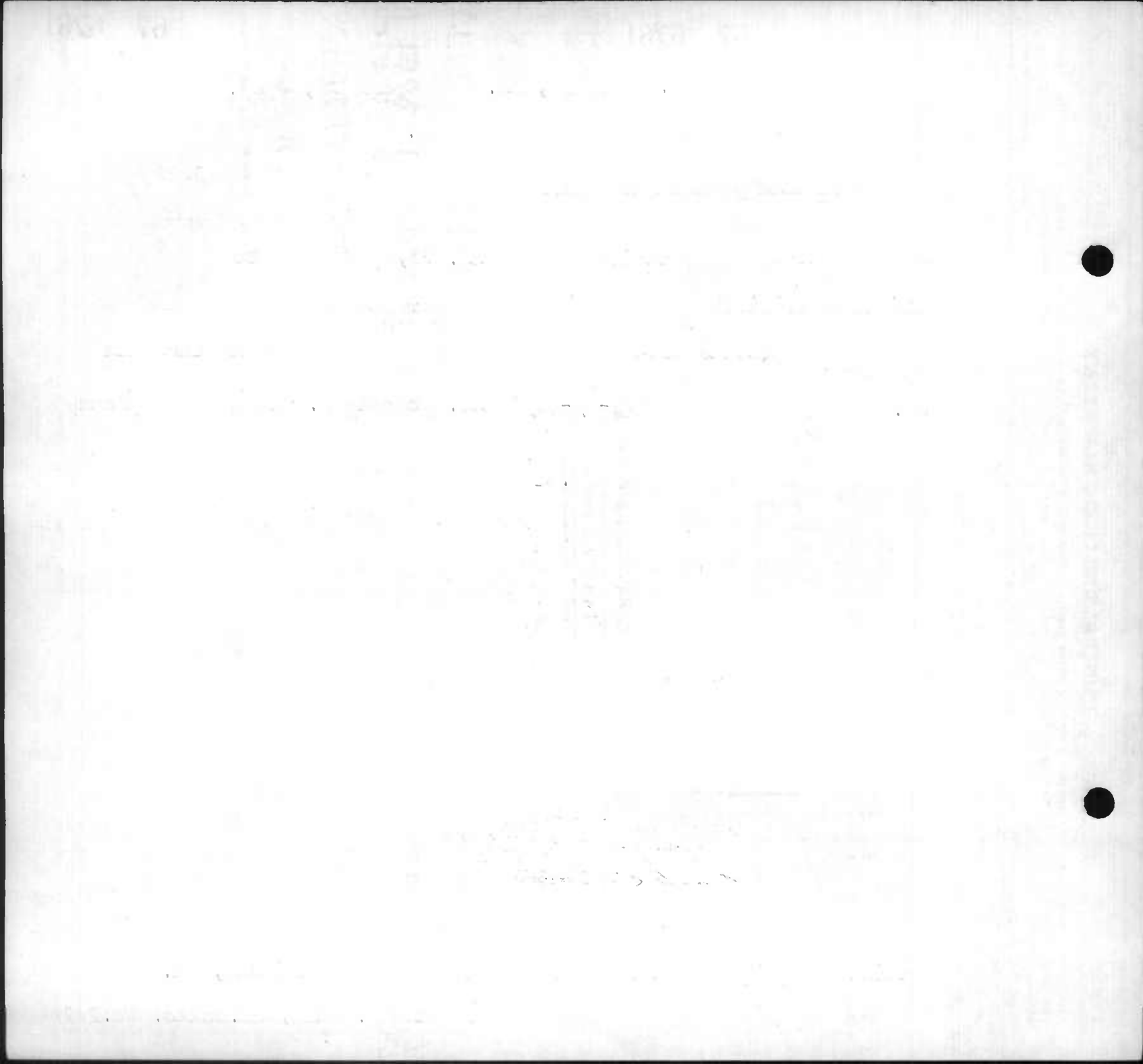
24C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck Inc., 5305 Harford Rd. #14


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

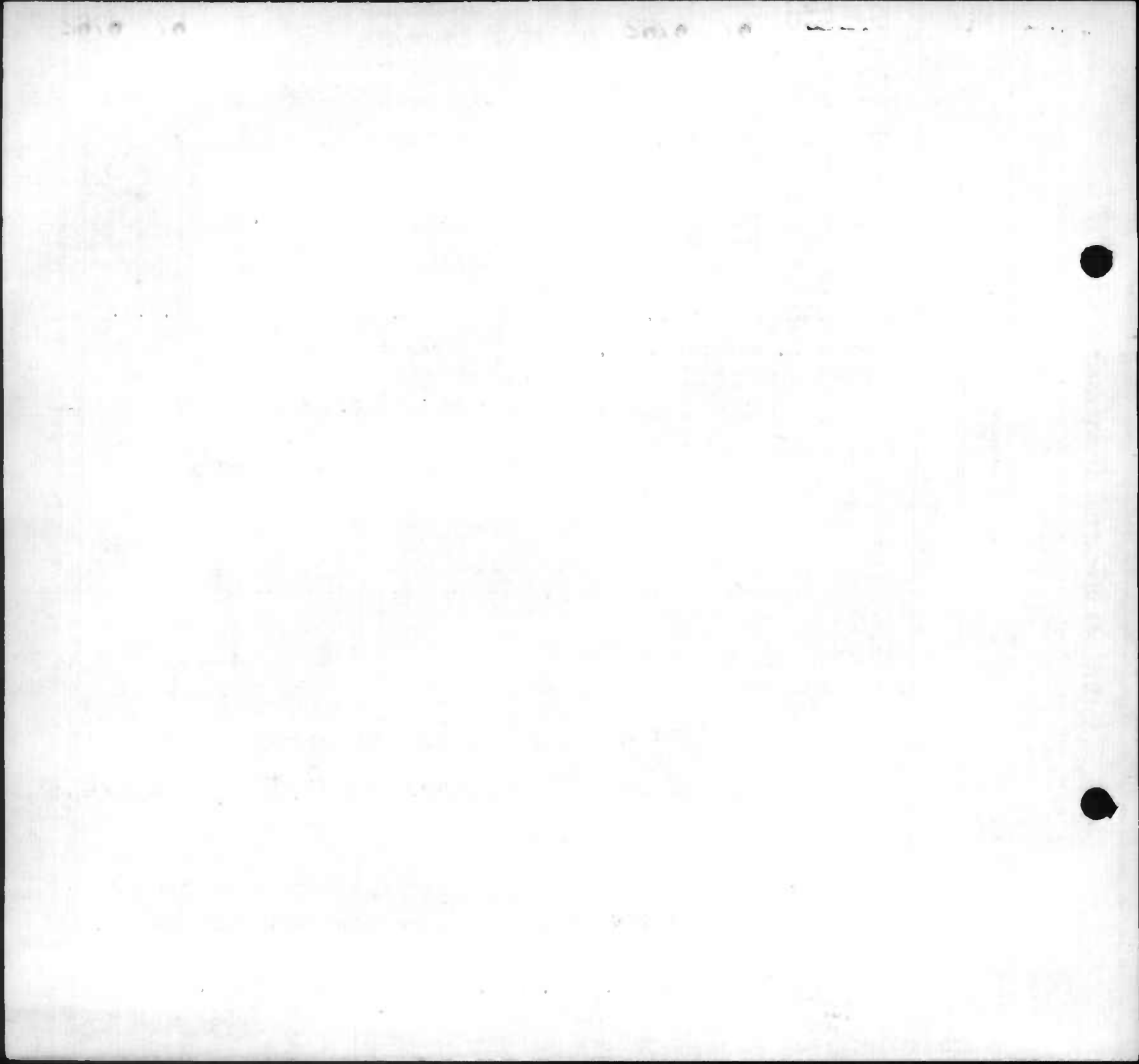
BIRTH NO. 67 6761				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6761	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Raymond C. Ashley, Sr.</i>			
2. DATE AND HOUR OF DEATH <i>July 12, 1967. 1 0 P.</i>				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland General Hospital</i>				A. STATE <i>Md.</i> B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21214 27-03</i>			
D. STREET ADDRESS (If rural, give location) <i>3008 Ailsa Avenue</i>							
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct. 11, 1900</i>	9. AGE (In years last birthday) <i>66</i>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Machinist</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Charles Ashley</i>			14. MOTHER'S MAIDEN NAME <i>Martha Lawrence</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unk.</i>			16. SOCIAL SECURITY NO. <i>275-07-4852</i>		17. INFORMANT <i>Mrs. Dorothy S. Ashley</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>420.11</i>			19. CAUSE OF DEATH <i>Acute Coronary Insufficiency 1 hour</i> <i>Coronary Sclerosis 5 years</i>		INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1940</i> 19 to <i>7-12-67</i> 19, that (I) (we) last saw the deceased alive on <i>5-6-67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.							
23A. SIGNATURE <i>C. W. Peake</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7-13-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>C. W. PEAKE</i>				23D. ADDRESS <i>4508 Hanford Road, Balto 21214</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/15/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 14 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto.</i>		ADDRESS <i>Md. 21214</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

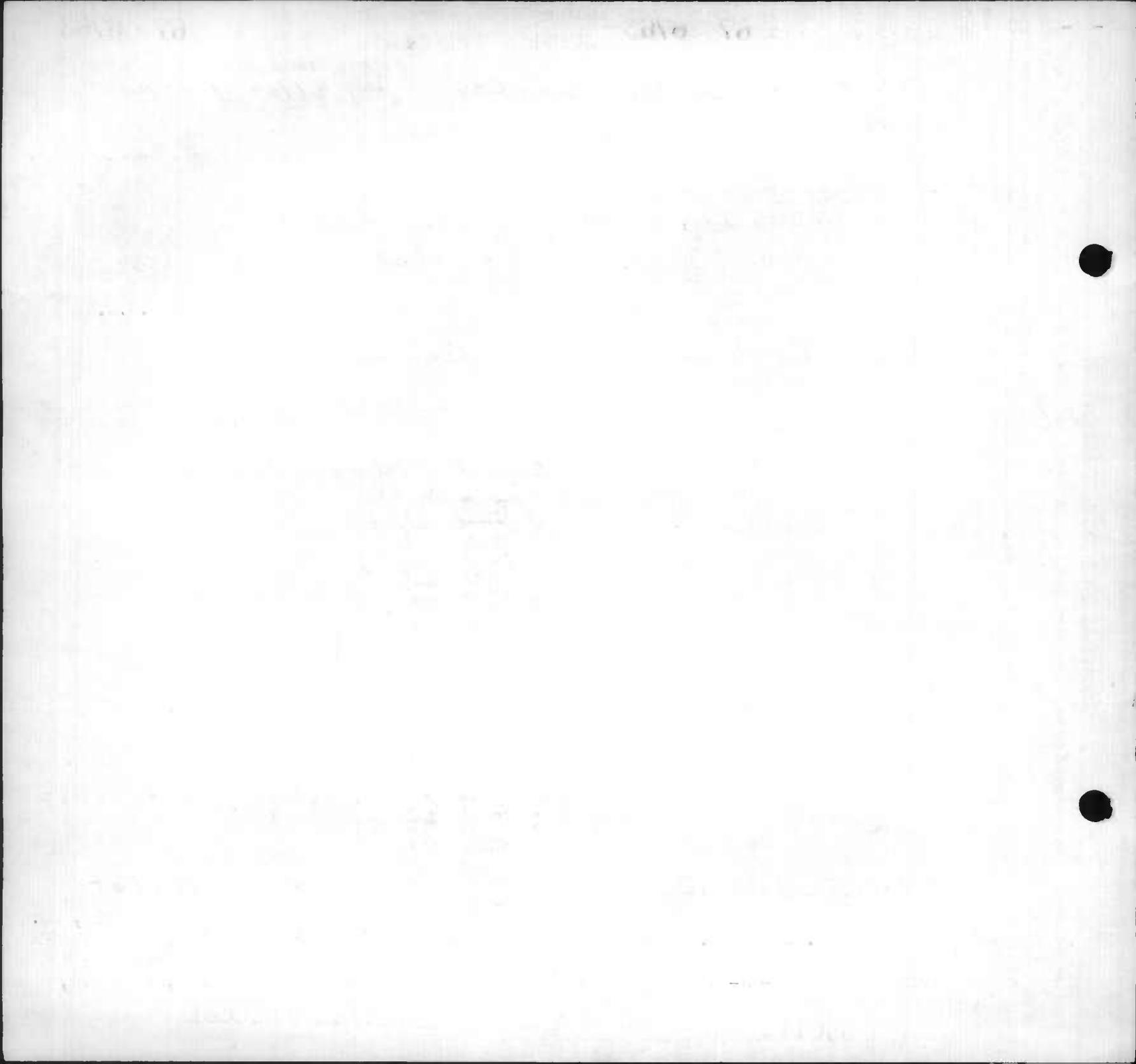
BIRTH NO. 67 6762		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6762	
1. NAME OF DECEASED (Type or Print) GEORGE EDWARD DeFOREST			2. DATE AND HOUR OF DEATH 7/13/67 12¹³ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 623 HOMESTEAD ST.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 10/7/30	9. AGE (In years last birthday) 36	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OBSERVER			10B. KIND OF BUSINESS OR INDUSTRY BETH. STEEL		11. BIRTHPLACE (State or foreign country) MASS.
13. FATHER'S NAME Charles R. DeForest, Sr.			14. MOTHER'S MAIDEN NAME Theresa Wool		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES KOREAN WAR			16. SOCIAL SECURITY NO. 016-24-3212		17. INFORMANT ADDRESS ELIZABETH J. DeFOREST 623 HOMESTEAD ST
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 433.10 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH (A) VENTRICULAR STANDSTILL DUE TO AD (B) _____ DUE TO _____ (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-13-67 to the time of death , that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) T DORMAN				23B. DATE SIGNED 7/13/67	
23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL BALTO.					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 7/17/67	24C. NAME OF CEMETERY or CREMATORY BALTO. NAT. CEM.	24D. LOCATION (City, town, or county) (State) BALTIMORE MD.		
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS HENRY W. JENKINS & SONS 4905 YORK ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 49-66-08 GG 1 -363 </div>		<div style="display: flex; justify-content: space-between;"> 67-14332 67 6763 </div>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6763 ✓	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67-14332 67 6763 </div>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) STROUD, IDA MAE BABY BOY				2. DATE AND HOUR OF DEATH July 9, 1967, 1:40 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND BALTIMORE CITY HOSPITALS FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1516 WOLF ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 7/7/67	9. AGE (In years last birthday) -	If Under 1 Yr. Months: Days: Hours: Min. (2)		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ALEX STROUD				14. MOTHER'S MAIDEN NAME IDA MAE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ALEX STROUD		ADDRESS 1516 WOLF ST.
18. 768, 5 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure (Atelectasis, pneumonia?) ANTECEDENT CAUSES (B) Immaturity & (Sepsis?) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) this hospital attended the deceased from July 7 19 67 to July 9 , 19 67 . that (I) we last saw the deceased alive on July 9 19 67 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) We (did) (did not) view the body after death.							
23A. SIGNATURE RAQUEL V. MONTEZUMA				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/9/67	
23C. PHYSICIAN'S NAME (Type) DR. RAQUEL V. MONTEZUMA				23D. ADDRESS BALTIMORE 21224, MD. BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 7-11-67		24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Maryland 4940 Eastern Avenue, Baltimore,	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Jul 17 1967 Robert E. Farley		25C. FUNERAL DISPOSAL HOSPITAL DISPOSAL		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67. 6764	
BIRTH NO. 67. 6764				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SARAH NEAL OR SALLY ONKEY		2. DATE AND HOUR OF DEATH 7-9-1967 2:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nurs. Home		A. STATE MARYLAND B. COUNTY 9.9. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BOWE WATER D. STREET ADDRESS (If rural, give location) Rt. 2 Box 132			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9-13-1881	9. AGE (In years last birthday) 85	If Under 1 Yr. Months; Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Ned Olney		14. MOTHER'S MAIDEN NAME Conelia Boston		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Chart # 539, 607 Penna. Ave.	
18. 430.01		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Generalized Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 8	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Chronic Brain Syndrome		5	
		(C) Coronary Heart Condition		35 min.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 7, 1962 to July 9, 1967 , that (I) was last saw the deceased alive on 7/6 19 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE E. E. Neel		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/9/67	
23C. PHYSICIAN'S NAME (Type) Edward E. Neel		23D. ADDRESS 3715 Liberty Heights			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-13-1967		24C. NAME of CEMETERY or CREMATORY Chews Memorial	
24D. LOCATION ANNE ARUNDEL Md		25A. DATE RECEIVED BY HEALTH DEPT. JUL 17 1967			
25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR Thick's Funeral			
		ADDRESS Annapolis Md			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6765	
M-360 67 6765		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) MATHER, FLORENCE		2. DATE AND HOUR OF DEATH 14 JULY 1967 6:57 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 1940 Eastern Ave. Baltimore, Maryland # 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-12	
D. STREET ADDRESS (If rural, give location) 4940 Eastern Ave. # 21224			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9/6/91
9. AGE (In years last birthday) 75		10. DATE OF DEATH If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOSPITAL AIDE		10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSHUA GREAVES		14. MOTHER'S MAIDEN NAME LENA - RICKER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. - NONE	
17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md.		ADDRESS # 21224	
18. 434.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA INTERVAL BETWEEN ONSET AND DEATH 2 DAYS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGESTIVE HEART FAILURE 5 YRS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC BRONCHITIS & EMPHYSEMA 10 YRS.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? —			
22. I certify that 49 (this hospital) attended the deceased from 29 April 1966 to 14 JULY 1967 . that 49 (we) last saw the deceased alive on 14 JULY 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. 49 (We) (did) (did not) view the body after death.			
23A. SIGNATURE Russell D. Hicks		23B. DATE SIGNED 14 JULY 1967	
23C. PHYSICIAN'S NAME (Type) Russell D. Hicks		23D. ADDRESS 4940 EASTERN AVE BALTIMORE MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/17/67	
24C. NAME OF CEMETERY or CREMATORY St. Mary's Cem., Hampden		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Witzke F. D.		ADDRESS - 4101 Edmondson Av.	

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FUNERAL DIRECTOR: IMPORTANT

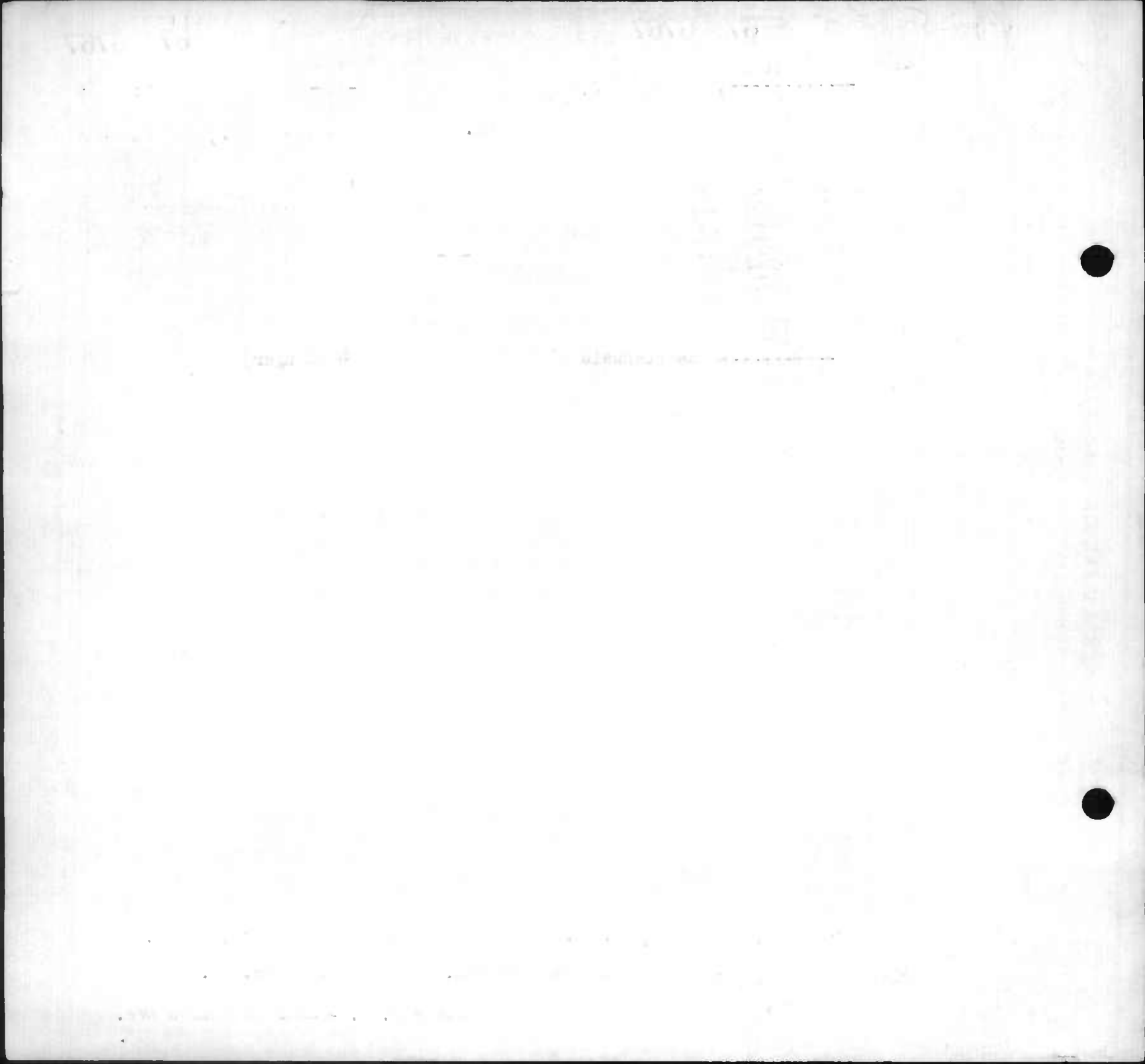
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>4-200 67 6766</p> <p style="font-size: 1.2em;">BIRTH NO. 67 6766</p>		<p>CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em;">CERTIFICATE OF DEATH</p>		<p>Registered No. 67 6766</p>	
<p>M.E. CASE NO.</p>					
<p>1. NAME OF DECEASED (Type or Print) HICKEY MARIE B</p>			<p>2. DATE AND HOUR OF DEATH 7/14/67 8:30 A.M.</p>		
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND GEN'L HOSPITAL <small>FULL NAME OF HOSPITAL OR INSTITUTION</small> <small>or not in hospital or institution, give street address or location</small> BALTIMORE, MARYLAND 48</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12-02 D. STREET ADDRESS (If rural, give location) 2922 St. Paul St.</p>		
<p>5. SEX F</p>	<p>6. RACE Can</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED</p>	<p>8. DATE OF BIRTH 5-4-94</p>	<p>9. AGE (In years last birthday) 73</p>	<p>If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY —</p>		<p>11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND</p>	
<p>13. FATHER'S NAME August Bouc HAS</p>			<p>14. MOTHER'S MAIDEN NAME MARY BRAUNLEIN</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>16. SOCIAL SECURITY NO. 219-12-5622</p>		<p>17. INFORMANT ADDRESS Mrs. Charles Henderson 2909 Guilford Av.</p>	
<p>18. 152.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			<p>CAUSE OF DEATH (A) METASTATIC ADENOCARCINOMA OF SMALL INTESTINE & INTESTINAL OBSTRUCTION (B) — (C) —</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS</p>
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION 7-7-67</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SMALL BOWEL OBST</p>		<p>20A. AUTOPSY? (Yes or No) —</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —</p>		<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? —</p>	
<p>22. I certify that (1) (this hospital) attended the deceased from 7-2-67 19 to 7-14-67 19, that (1) (we) last saw the deceased alive on 7-14-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Robert M. Beazley</p>				<p>23B. DATE SIGNED 7/14/67</p>	
<p>23C. PHYSICIAN'S NAME (Type) ROBERT MONTAGUE BEAZLEY</p>				<p>23D. ADDRESS MARYLAND GEN'L HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 7/17/67</p>		<p>24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.</p>	
<p>24D. LOCATION (City, town, or county) (State) Baltimore, Md.</p>		<p>25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967</p>			
<p>25B. NAME OF REGISTRAR Robert E. Fairley, M.D.</p>		<p>25C. FUNERAL DIRECTOR ADDRESS Witzke F. D. - 4101 Edmondson Av.</p>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CITY HEALTH DEPARTMENT				BIRTH NO.		67. 6767		CERTIFICATE OF DEATH		Registered No. 67. 6767	
1. NAME OF DECEASED (Type or Print) RECKTENWALD, JOSEPH J.				2. DATE AND HOUR OF DEATH 7-13-67 10:50PM M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) COMMUNITY NURSING HOMES INC 90 BOLTON HILL NURSING CENTER				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Maryland D. STREET ADDRESS (If rural, give location) Bolton Hill Nursing Center							
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 1-7-1875		9. AGE (In years last birthday) 92	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Andrew Reckenwald Recktenwald				14. MOTHER'S MAIDEN NAME Elizabeth (Sanger)							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury at complication which caused death.) 610X I Uremic Poisoning				CAUSE OF DEATH (A) DUE TO Uremic Poisoning				INTERVAL BETWEEN ONSET AND DEATH Several weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Urinary tract infection Prostatic Hypertrophy & obstruction				(B) DUE TO Urinary tract infection				(C) Prostatic Hypertrophy & obstruction			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 13, 1967 to July 13, 1967 , that (I) (we) last saw the deceased alive on July 13, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Reuben Yaffe Doctor Kenneth Yaffe				M.D. <input checked="" type="checkbox"/> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/14/67					
23C. PHYSICIAN'S NAME (Type) Doctor Kenneth Yaffe, M.D.				23D. ADDRESS 5501 Forest Park Ave. Balt. Md							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/17/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967				25B. NAME OF REGISTRAR Robert E. Fader				25C. FUNERAL DIRECTOR Witake F. D. - 4101 Edmondson Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-324		67 6768		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6768	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				STIGLER, CARL		JULY 10, 1967 10:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
ST. AGNES HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				3 SOUTH GLEN AVE.			
				D. STREET ADDRESS (If rural, give location)			
				DELLA, MARYLAND 21116			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
MALE	WHITE	WIDOWED	8/31/88	78			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED		TEXTILE Mill		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN Randal Ph Stigler				UNKNOWN Katherine Tommy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES WWI		213-09-1118		ST. AGNES HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		If in Baltimore City, give exact location	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from JULY 9 1967 to JULY 10 1967, that (I) (we) last saw the deceased alive on JULY 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Paulino D. Vasallo						7-10-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Paulino D. Vasallo				M.D. ST. AGNES HOSP; CATON & WILKENS AVES.		21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-14-67		NEW Cathedral		BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 17 1967		Robert E. Jarboe		Highway Home		Fellows Hill	

TITLER, CARL

JULY 10 1947

MARYLAND

1 - 10TH BLEN AVE.

DELLA, MAR LANE 21114

ST. AGNES HOSPITAL

MALE WHITE WIDOWED

DECEASED

MARYLAND

U.S.A.

YES 211-24115 ST. AGNES HOSPITAL REPORT

JULY 10

JULY 5

JULY 10

ST. AGNES HOSPITAL & WILLIAMS AVE.

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67 6769

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6769

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) DAVID KEITH				2. DATE AND HOUR PRONOUNCED DEAD July 13, 1967 2:45 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 436 South Baltimore General Hospital (DOA)				4. USUAL RESIDENCE (Where deceased lived, if institution: residence, before admission) A. STATE Maryland B. COUNTY Baltimore Co C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 3167 Bero Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH October 11, 1942	9. AGE (In years last birthday) 24	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME late Darryle Keith				
14. MOTHER'S MAIDEN NAME Vera Garrett			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes				
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS mrs Vera Keith 3167 Bero Rd.				
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple traumatic injuries (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2-13-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Intersection of Key Highway and Clement Street 24-01			
21D. TIME OF INJURY (APPROX.) 7-13-67 2:05 A.M.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Driver in auto - fixed object collision			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 13, 1967							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE July 17, 1967		23C. NAME OF CEMETERY or CREMATORY Baltimore National		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		24B. NAME OF REGISTRAR Robert E. Fairbanks		24C. FUNERAL DIRECTOR Howard County Funeral Home of Harry Witzke		ADDRESS Ellicott City Maryland	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6770</u>	
BIRTH NO. <u>67 6770</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BURGESS, JOHN CHARLES		2. DATE AND HOUR OF DEATH JULY 12, 1967 9:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL <i>40</i>		A. STATE MARYLAND B. COUNTY <i>Howard Co.</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLCOTT CITY <i>63-00</i>			
		D. STREET ADDRESS (If rural, give location) 563 FREDERICK RD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/23/98	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY B & O RR		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ELMER E. BURGESS DEC'D			
14. MOTHER'S MAIDEN NAME ROSETTA (BELL) BURGESS DEC'D		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT CATON & WILKENS AVE. S, BALTO., MD. 21229 HOSPITAL RECORDS-ST. AGNES HOSPITAL			
18. <i>4201</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Myocardial infarction, acute</i> (B) <i>ASVD</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 10, 1967 to JULY 12, 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JULY 12, 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <i>S. Korbuly</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 07-12-67	
23C. PHYSICIAN'S NAME (Type) S. KORBULY		23D. ADDRESS St. Agnes Hospital - Caton & Wilkens			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-15-67		24C. NAME OF CEMETERY or CREMATORY ST. JOHNS.	
24D. LOCATION ELLCOTT CITY, MD		25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967			
25B. NAME OF REGISTRAR Robert E. Fickens		25C. FUNERAL DIRECTOR Higginbotham - Slack Funeral of Home			
25D. ADDRESS ELLCOTT CITY, MD					

DATE: JULY 12, 1952

JULY 12, 1952

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

WANTED

WHITE

MALE

DOB: 12-1-1928

DOB: 12-1-1928

DEC 10

ELMER E. BURGESS

UNKNOWN

UNKNOWN

YES

ROBERT (WIFE) 12-1-1928
CAYEN & WILKINS 12-1-1928
HOSPITAL RECORDS - ST. ALBANS HOSPITAL

JULY 12, 1952
X

JULY 10, 1952

JULY 10, 1952

X

07-12-52
St. Albans Hospital - Mr. Williams

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 6771	
BIRTH NO. 67 6771				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) LAFRANCE, ALBERT				2. DATE AND HOUR OF DEATH JULY 11, 1967 1:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL 100 NORTH BROADWAY BALTIMORE, MARYLAND 21231				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 2617 YORK WAY			
5. SEX M	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH AUG. 6, 1902	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME UNKNOWN LA FRANCE				14. MOTHER'S MAIDEN NAME UNKNOWN CARMELIA CARMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 705-12-4014		17. INFORMANT ADDRESS MRS LYDIA MAE LAFRANCE 2617 YORK WAY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRO-VASCULAR ACCIDENT				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO METASTATIC LUNG CANCER			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-19 1967 to 7-11 1967, that (I) (we) last saw the deceased alive on 7-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jose G. Ortiz				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-11-67	
23C. PHYSICIAN'S NAME (Type) JOSE G. ORTIZ				23D. ADDRESS CHURCH HOME & HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/14/67		24C. NAME OF CEMETERY or CREMATORY LA FAYETTE MEMORIAL		24D. LOCATION (City, town, or county) (State) UNION TOWN PA	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR P. D. & E. F. J. J.		25C. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOME-DUNDALK MD			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6772	
BIRTH NO. 67 6772		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA MARIE CHETELAT		2. DATE AND HOUR OF DEATH JULY 2, 1967 5:50P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL WILKENS & CATON AVE BALTIMORE, MD. 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3306 MCSHANE WAY			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11/23/92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? USA (55 YRS)		13. FATHER'S NAME UNKNOWN DEC 'D		14. MOTHER'S MAIDEN NAME UNKNOWN DEC 'D	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213078922A		17. INFORMANT ADDRESS ST. AGNES RECORDS WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 332X17260X Cerebral Infarct Internal Carotid Artery Thrombosis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that XX (his hospital) attended the deceased from 7/1/67 19 to 7/2/67 19 that X (we) last saw the deceased alive on 7/2/67 19 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) XXXX view the body after death.		23A. SIGNATURE George Patrick M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) G. PATRICK		23D. ADDRESS 21229 ST. AGNES HOSP; WILKENS & CATON AVES.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE July 7/67		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) Baltimore County		25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Ullrich Funeral Home		25D. ADDRESS 2112 Dundalk Ave			

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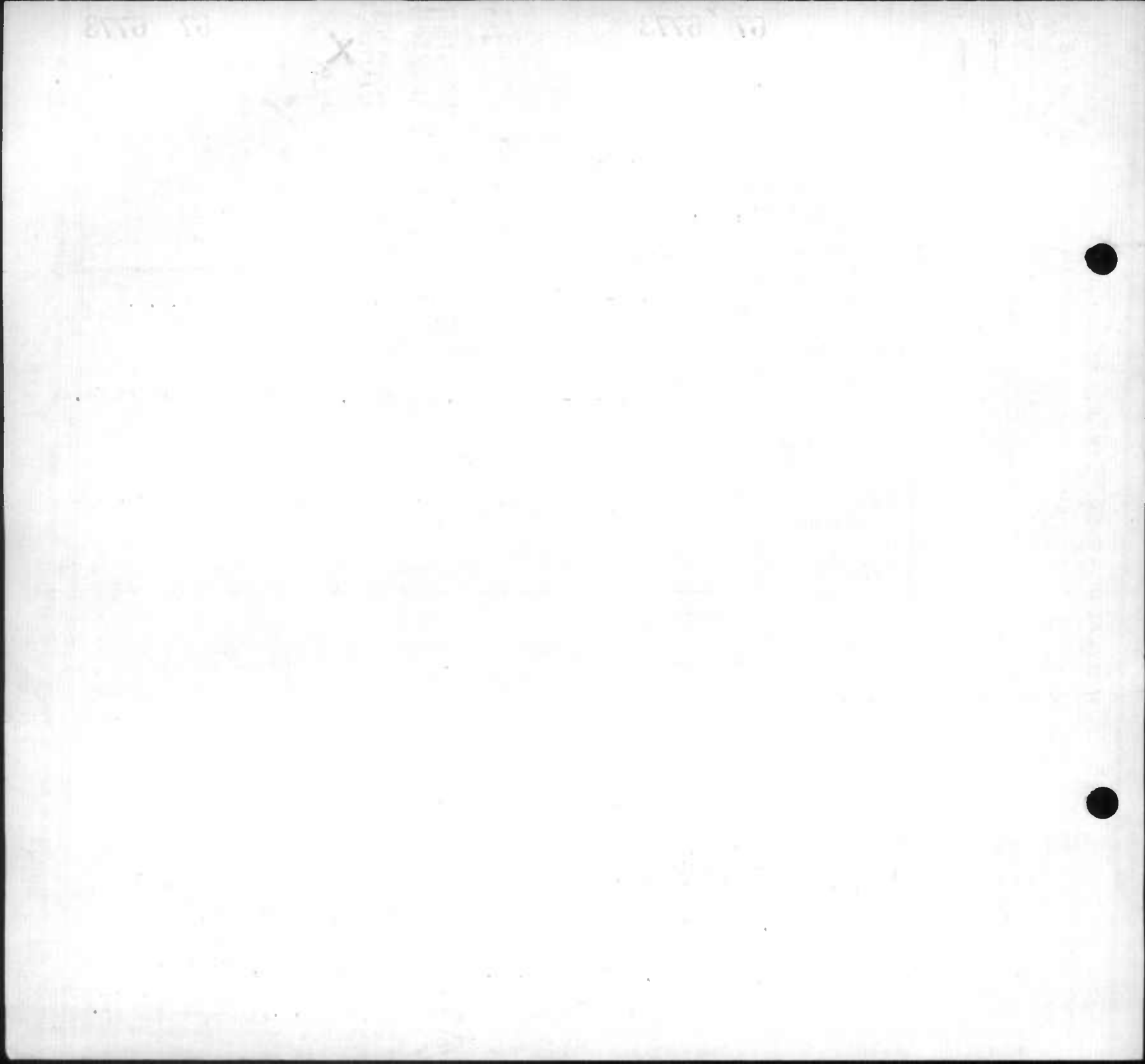
1967, 2 JUL

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 6773	
BIRTH NO. 67 6773							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) NEWTON E. TAYLOR				2. DATE AND HOUR OF DEATH 7/5/67 4:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Md. 21224				A. STATE Maryland B. COUNTY Balts. Co			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Turner Station 53-00			
				D. STREET ADDRESS (If rural, give location) 217 Chestnut Street #22			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/26/1904	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem-Steel		11. BIRTHPLACE (State or foreign country) Cumberland, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Taylor				14. MOTHER'S MAIDEN NAME Mary Taylor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-4008		17. INFORMANT ADDRESS Mrs. Carrie L. Taylor 217 Chestnut St.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infraction (A) DUE TO Arteriosclerotic Heart Disease				3 years			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/2 19 65 to present 19 67 , that (I) (we) last saw the deceased alive on 6/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Theo C Patterson				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/7/67	
23C. PHYSICIAN'S NAME (Type) Theo C. Patterson				23D. ADDRESS M.D. 105 Main Street, 21222			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/67		24C. NAME of CEMETERY or CREMATORY Mt. Olive Bapt. Ch. Cem		24D. LOCATION (City, town, or county) (State) Cumberland, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett F.H., 1701 Laurens St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6774	
67 6774				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Shaw, Maggie		July 13 - 1967 2:00 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		A. STATE MARYLAND B. COUNTY X			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5-01			
		D. STREET ADDRESS (If rural, give location) 236 SILVER COURT 21231			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-31-99	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. C.	
13. FATHER'S NAME MACK MOORE		14. MOTHER'S MAIDEN NAME FRANCES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Bertha Allen 1720 E. Chase II	
18. 754X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Probable Pulmonary Embolus or Myocardial Infarction		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 26 1967 to July 13 1967, that (I) (we) last saw the deceased alive on July 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dudley D. Goulden III M.D.				23B. DATE SIGNED 7/13/67	
23C. PHYSICIAN'S NAME (Type) DUDLEY D. GOULDEN, 3RD M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/17/67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION (City, town, or county) (State) D. D. County, MD		25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Joseph G. Lock Jr. 1304 N. Central Ave			

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July 13

2000-10-31

Probable Pulmonary
Emboli or
Myocardial Infarction

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2000-10-31

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Dr. H. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6775
BIRTH NO. 67 6775		CERTIFICATE OF DEATH		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 7-13-67 1 PM		
1. NAME OF DECEASED (Type or Print) KLINE, MILDRED HESS		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 552 S. 45th St 21224 53-00 D. STREET ADDRESS (If rural, give location) DUNDALK		
5. SEX FEM.	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-13-90	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME SAMUEL HESS		14. MOTHER'S MAIDEN NAME LACRA LESSICK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-225730	17. INFORMANT HOSPITAL ADDRESS	
18. 420.11		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) CEREBRAL THROMBOSIS		
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(B) ARTERIOSCLEROSIS HEART DISEASE		
ANTECEDENT CAUSES		(C)		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mural thrombi, heart				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes in part
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7-6-1967 to 7-13-1967 , that (I) (we) last saw the deceased alive on 7-13-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) CARLOS ARANAGA				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/18/67		24C. NAME OF CEMETERY or CREMATORY ST. MARKS
24D. LOCATION (City, town, or county) (State) LEWISTOWN, PENNA.		25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR W. Parker Bradley, Harford, MD		

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-425 BIRTH NO.		67 6776		CITY OF BALTIMORE		Registered No. 67 6776	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) RUTH J. KLOSIINSKI			
2. DATE AND HOUR OF DEATH 7/12/67 8:30 P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 Eastern Avenue Baltimore, Maryland #21224 Baltimore City Hospitals			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 1219 BROENING HWY #21224		5. SEX Female	
6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 9/13/23		9. AGE (In years lost birthday) 43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Wild				14. MOTHER'S MAIDEN NAME (Wild) ELZA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH		18. ADDRESS 4940 Eastern Avenue Baltimore, Maryland #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA DUE TO				INTERVAL BETWEEN ONSET AND DEATH DAYS			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. METASTATIC CARCINOMA TO DUE TO ADENOCARCINOMA OF UTERINE CERVIX 3-4 YRS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION Tot. Abd. Hyst.		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENOCARCINOMA OF UTERINE CERVIX		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/27 19 67 to 7/12 19 67, that (I) (we) last saw the deceased alive on 7/12/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE B. W. GATTIS				23B. DATE SIGNED 7/12/67			
23C. PHYSICIAN'S NAME (Type) B. W. GATTIS				23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. #24 Baltimore City Hospitals			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Walter Dabrowski		ADDRESS 1005 Dundalk Avenue	

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ROTH & KROBINSKI
April 8 1964

Mr.

Baltimore City Hospital
F W Williams
Baltimore, Md
21201

PNEUMONIA
TO
METASTATIC CARCINOMA
ADENOCARCINOMA OF LUNG

operation 7-27-64 confirmed by biopsy 7-18-67

Baltimore City Hospital
4/10/67
4/10/67
4/10/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6777				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6777	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) CRUE, WALTER SINGLETON				July 13, 1967 3:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				A. STATE B. COUNTY Maryland Baltimore Co.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glyndon 53-00			
				D. STREET ADDRESS (If rural, give location) Railroad Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 3/23/1894	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply & Equip Manager Heavy Equipment			10B. KIND OF BUSINESS OR INDUSTRY Heavy Equipment		11. BIRTHPLACE (State or foreign country) Baltimore County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Crue				14. MOTHER'S MAIDEN NAME Queen Harris			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/4/17 - 5/21/19		16. SOCIAL SECURITY NO. 213-09-2372		17. INFORMANT ADDRESS VA Hospital Records, Baltimore, Md 21218			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO INTERVAL BETWEEN ONSET AND DEATH 20 years ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial Infarction DUE TO 6 hours							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 13th 19 67 to July 13th 19 67 , that (I) (we) last saw the deceased alive on July 13th 19 67 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Barnard S. Karpers, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/13/67	
23C. PHYSICIAN'S NAME (Type) BARNARD S. KARPERS, JR.				23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Boulevard, Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/17/67		24C. NAME OF CEMETERY or CREMATORY Sater's Baptist Ch. Cem. Baltimore Co., Maryland.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H.J. Scherardt		ADDRESS Owings Mills, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6778				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 877 6778 R 1.	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ESTELLA L. RUFF				2. DATE AND HOUR OF DEATH 7-14-67		7.45 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence, before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				A. STATE MARYLAND HARFORD Co.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) JOPPA			
				D. STREET ADDRESS (If rural, give location) 2015 SINGER ROAD			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 8-27-07	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME DAVID RUFF				14. MOTHER'S MAIDEN NAME MARY HENSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 125-24-4055		17. INFORMANT Mary Ruff		ADDRESS Joppa Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cram neg sepsis Laenare's Cirrhosis				INTERVAL BETWEEN ONSET AND DEATH ca 5 days ca 6 mo			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 1 19 67 to July 14 19 67, that (I) (we) lost saw the deceased olive on July 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas C. Butler				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/14/67	
23C. PHYSICIAN'S NAME (Type) THOMAS C. BUTLER				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-17-67		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Balt Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR A. E. F. F. F.		25C. FUNERAL DIRECTOR Frances A. Henneley		ADDRESS 578 W Biddle St	

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From very recent
Lancaster (Indiana)

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Thomas C. Butler

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11/1/12

July 14 1912

July 14 1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6779		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6779	
M.E. CASE NO.		Dorothy E. Shoemaker		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) DOROTHY S. SHOEMAKER		2. DATE AND HOUR OF DEATH 7/12/67 2:33 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL of BALTIMORE INC 42		A. STATE Md. Baltimore B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4920 Gateway Terrace 1336 REGINA DR BALTO. MD			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 1/29/23	9. AGE (In years last birthday) 44	10. AGE (In years last birthday) 44
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawrence Clerk		10B. KIND OF BUSINESS OR INDUSTRY R.R. I.B.M., Western, Md.		11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME George Alexander Shoemaker		14. MOTHER'S MAIDEN NAME Catherine E. Housholder		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-18-1181		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 199.2.1		CAUSE OF DEATH (A) Malignant carcinoma origin UNKNOWN (B) hepatic metastasis (C)		INTERVAL BETWEEN ONSET AND DEATH 12/66 to 7/12/67	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. dehydration			
19A. DATE OF OPERATION 25/1/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HEPATIC METASTASIS		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/1/67 to 7/12/67		1967		1967 and that in (my) (our) opinion death occurred on the date 6/12/67	
23A. SIGNATURE Alan F. Wolf		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/12/67	
23C. PHYSICIAN'S NAME (Type) ALAN F. WOLF		23D. ADDRESS 1336 REGINA DR BALTO. MD C/O SINAI Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-67		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Howard County, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 6780

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Charles Flatt

2. DATE AND HOUR OF DEATH

July 11, 1967

3 55 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)31
Balto. City Hosp.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md. Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Essex

D. STREET ADDRESS (If rural, give location)

901 Mace Ave.

5. SEX
M6. RACE
W7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
S8. DATE OF BIRTH
May 17, 1894 739. AGE (In years
last birthday)
If Under 1 Yr. Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tinner Ret.

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.1

16. SOCIAL
SECURITY NO.

213-07-0279

17. INFORMANT

ADDRESS

Mrs Elsa Ermer 9206 Hines Rd. 21234

18. 42011
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, (giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

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19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/24 1959 to 7/11 1967.
that (I) (we) last saw the deceased alive on 6/25 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

JOSEPH MICELE

M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

7/14/67

23D. ADDRESS

M.D.

108 S. TAYLOR AVE

ESSEX, MD
2122124A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/14/67

24C. NAME OF CEMETERY or CREMATORY

Zion Luth. Cem.

24D. LOCATION

(City, town, or county)

Balto. Co. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 17 1967

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

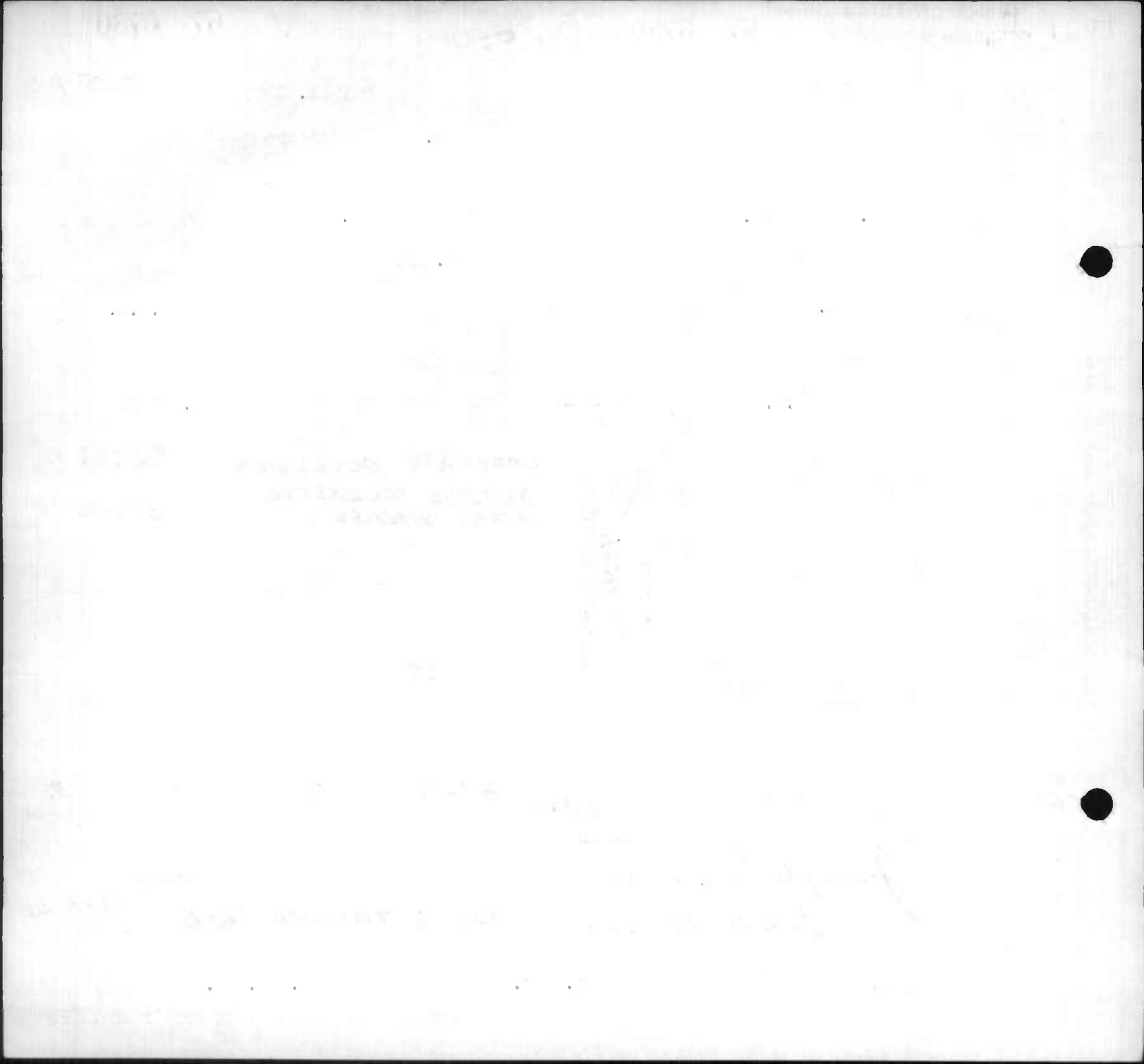
25C. FUNERAL DIRECTOR

ADDRESS

Lassahn Funeral Home 7401 Belair Rd 21236

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6781	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67. 6781 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mrs Leona V. Cooper			2. DATE AND HOUR OF DEATH 6.30 a.m. 7/8/67		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital </div> <div> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MO. B. COUNTY Hartford Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 62-32 D. STREET ADDRESS (If rural, give location) 133 Archer St. Belair Md		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 8/26/09	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10B. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Hartford Co. MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David Haines			14. MOTHER'S MAIDEN NAME Hollie Harris		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Nathan Cooper, Bel Air, Md. ADDRESS 133 Archer St.		
18. 600.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Electrolyte imbalance DUE TO (B) severe acute pyelo nephritis DUE TO (C) 3 days INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/26/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED hw dolorous		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/25/67 19 to 7/8/67 19, that (I) (we) last saw the deceased alive on 2.00 p.m. 7/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RAH/MI			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) A. RAH/MI			23D. ADDRESS Mercy Hospital Bal MO.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-67		24C. NAME of CEMETERY or CREMATORY Berkley Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor, Md	
25C. FUNERAL DIRECTOR Catalin J. Bullock, Harde de Shary, Md.		25D. ADDRESS 556 Leung St.			

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1870 10 05
1870 10 05

RELEASED Non-MED by Dr. RUSSEL FISHER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-13410 67. 6782		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6782	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) TIMOTHY MARK GUNSHOL		2. DATE AND HOUR OF DEATH 7/9/67 7²⁰ P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 232 E. MEDWICK GARTH			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 7-7-67	9. AGE (In years last birthday) 2	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME LOUIS GUNSHOL		14. MOTHER'S MAIDEN NAME DOROTHY DOERING	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Louis Gunshol	
18. 75451 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARDIAC ARREST DUE TO (B) CONGENITAL HEART DISEASE DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 45 minutes 2 days					
19. 7/9/67 DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CONG. HEART DISEASE		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 9 1967 to July 9 1967 , that (I) (we) lost saw the deceased alive on 7²⁰ P July 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen H. Polmar M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/9/67	
23C. PHYSICIAN'S NAME (Type) Stephen H. Polmar		23D. ADDRESS M.D. Johns Hopkins Hospital, Baltimore 21205			
24A. BURIAL CREMATION REMOVAL (Specify) 7/11/67		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Cathedral Am.	
24D. LOCATION (City, town, or county) (State) Baltimore IND.					
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Fairly - Cavanaugh	
ADDRESS 6601 Frederick Ave					

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CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CATHERINE KRAUK

2. DATE AND HOUR OF DEATH

7-12-67

7:58 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND #212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

MARYLAND, BALTIMORE Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

ESSEX

53-00

D. STREET ADDRESS (If rural, give location)

1021 EASTERN AVENUE #21221 005

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH

4-13-02

9. AGE (In years
last birthday)

65

10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSE-WIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

CHARLES KETTERING

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

212 05-76548

17. INFORMANT

BCH RECORDS:

ADDRESS

4940 EASTERN AVENUE
BALTIMORE, MARYLAND #2122418. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

MYOCARDIAL INFARCTION

INTERVAL BETWEEN
ONSET AND DEATH

10 minutes

DUE TO

CORONARY INSUFFICIENCY

INDIC -

DUE TO

ARTEROSCLEROSIS

INDIC -

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

NOT A MEDICAL EXAMINER'S CASE

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 19 67 to JUN 19 67,
that (I) (we) last saw the deceased alive on JUN 30 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

S.D. Kreider

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/12/67

23C. PHYSICIAN'S
NAME (Type)

S. D. KREIDER

M.D.

23D. ADDRESS

4940 EASTERN AVENUE BALTIMORE, MD. #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

7/15/67

24C. NAME OF CEMETERY or CREMATORY

OAK LAWN

24D. LOCATION

(City, town, or county)

BALTO. MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 17 1967

25B. NAME OF REGISTRAR

Robert E. Farley, MD

25C. FUNERAL DIRECTOR

CONNELLY SONS

ADDRESS

300 MACE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



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67 6784 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6784

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM L. BREHM

2. DATE AND HOUR PRONOUNCED DEAD

July 12, 1967

11:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3 N. Clinton Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-10

D. STREET ADDRESS (If rural, give location)

3 N. Clinton Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

8/18/1916

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

WESTINGHOUSE

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LOUIS W. BREHM

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL
SECURITY NO.

214-03-7645

17. INFORMANT

DOROTHY BREHM

ADDRESS

ABOVE

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK

NOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7/17/67

23C. NAME OF CEMETERY or CREMATORY

OAK LAWN

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

JUL 17 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

CONNELLY SONS

ADDRESS

300 MACE

1000

1000



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6785	
67 6785 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) REA. Hammond Keech, Sr. REA. H. KEECH			2. DATE AND HOUR OF DEATH July 13, 1967 2:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOUR HOSPITAL			A. STATE MARYLAND - 21227. Balt. Co		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 5156 Viaducto Ave.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/18/04	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automobile Dealer		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PHILEMOND KEECH			14. MOTHER'S MAIDEN NAME BESSIE REA.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-3537	17. INFORMANT ADDRESS Pt. Chart.		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Prothogenic Carcinoma (Metastatic)			INTERVAL BETWEEN ONSET AND DEATH 5 months.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cardiovascular Collapse.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 6/21/67 19 to 7/13 19 67 , that (I) (we) last saw the deceased alive on 7/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adm. Sec.			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/13/67
23C. PHYSICIAN'S NAME (Type) CESAR A. BRAVO			23D. ADDRESS BON SECOUR HOSPITAL.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/67	24C. NAME OF CEMETERY or CREMATORY St. Mary's Episcopal Church Cemetery		24D. LOCATION (City, town, or county) (State) Aquasco, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Sterling Funeral Estate-Catonsville, Md.	

PHILIPSON'S MEER
LITHOGRAPH DEPT.
WHITE
MAXIMS
2/11/04
BALTIMORE MD.
BESSIE BEN.

Grand Young Woman
(Portrait)

Grand Young Woman

40

2/12
2/15
2/15

2/15/04

Grand Young Woman

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

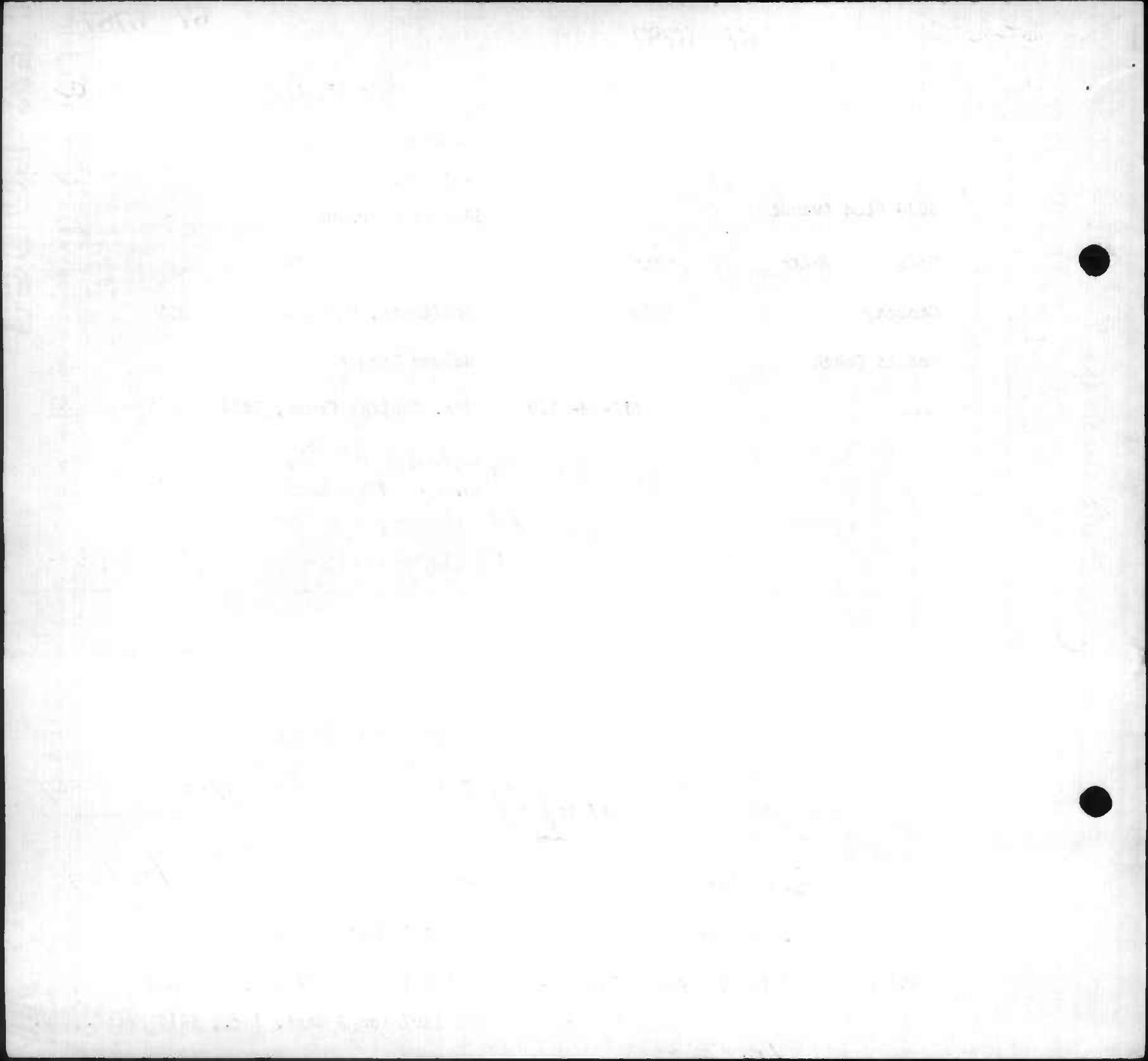
BALTIMORE CITY HEALTH DEPARTMENT									
67 6786 CERTIFICATE OF DEATH					Registered No. 67 6786				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) JOSEPH H FADER					2. DATE AND HOUR OF DEATH 7/12/67 12:00 AM.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL					A. STATE Md.				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTOP 53-00				
D. STREET ADDRESS (If rural, give location) 6 ALBESS CT, APT 3									
5. SEX M	6. RACE W	7. MARRIAGE STATUS Married	8. DATE OF BIRTH 8/21/31	9. AGE (In years last birthday) 35	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPPING CHANDLERS		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ABRAHAM FADER			14. MOTHER'S MAIDEN NAME SARAH			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 219-28-8543			17. INFORMANT Mrs. Terry Fader, Savoy Apartments, 6 Albess Ct., Apt 3				18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			20. INTERVAL BETWEEN ONSET AND DEATH HRS.						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
21A. DATE OF OPERATION			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 7/11/67 to 7/12/67.			that (I) (we) last saw the deceased alive on 7/12/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Francisco Baltazar			23B. DATE SIGNED 7/12/67			23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR			
23D. ADDRESS CHURCH HOME & HOSPITAL			23E. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/13/67			24C. NAME OF CEMETERY or CREMATORY Posvohler Friendly Society			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967			25B. NAME OF REGISTRAR Paul E. Fader			25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				67 6787		67 6787	
BIRTH NO.				M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Paul Cohen				July 12, 1967 7 ^a M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3004 Glen Avenue				A. STATE Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3004 Glen Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 60	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery		10B. KIND OF BUSINESS OR INDUSTRY Retail	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Morris Cohen			14. MOTHER'S MAIDEN NAME Nahama Brager				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-34-9539		17. INFORMANT Mrs. Pauline Cohen, 3004 Glen Avenue #15			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X CAUSE OF DEATH (A) Hypertensive Ht Dis Heart Failure (B) Ht Hemiplegia (C) pneumonia				INTERVAL BETWEEN ONSET AND DEATH 12 years 4 years 1 year 2 days, 5 -			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/5/67 to 7/12/67, that (I) (we) last saw the deceased alive on 7/11/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sol Smith M.D.				23B. DATE SIGNED 7/12/67			
23C. PHYSICIAN'S NAME (Type) Dr. Sol Smith				23D. ADDRESS 2500 Eutaw Place			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/67		24C. NAME OF CEMETERY or CREMATORY Anshe Emunah - (Aitz Chaim)		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.			



FUNERAL DIRECTOR: IMPORTANT

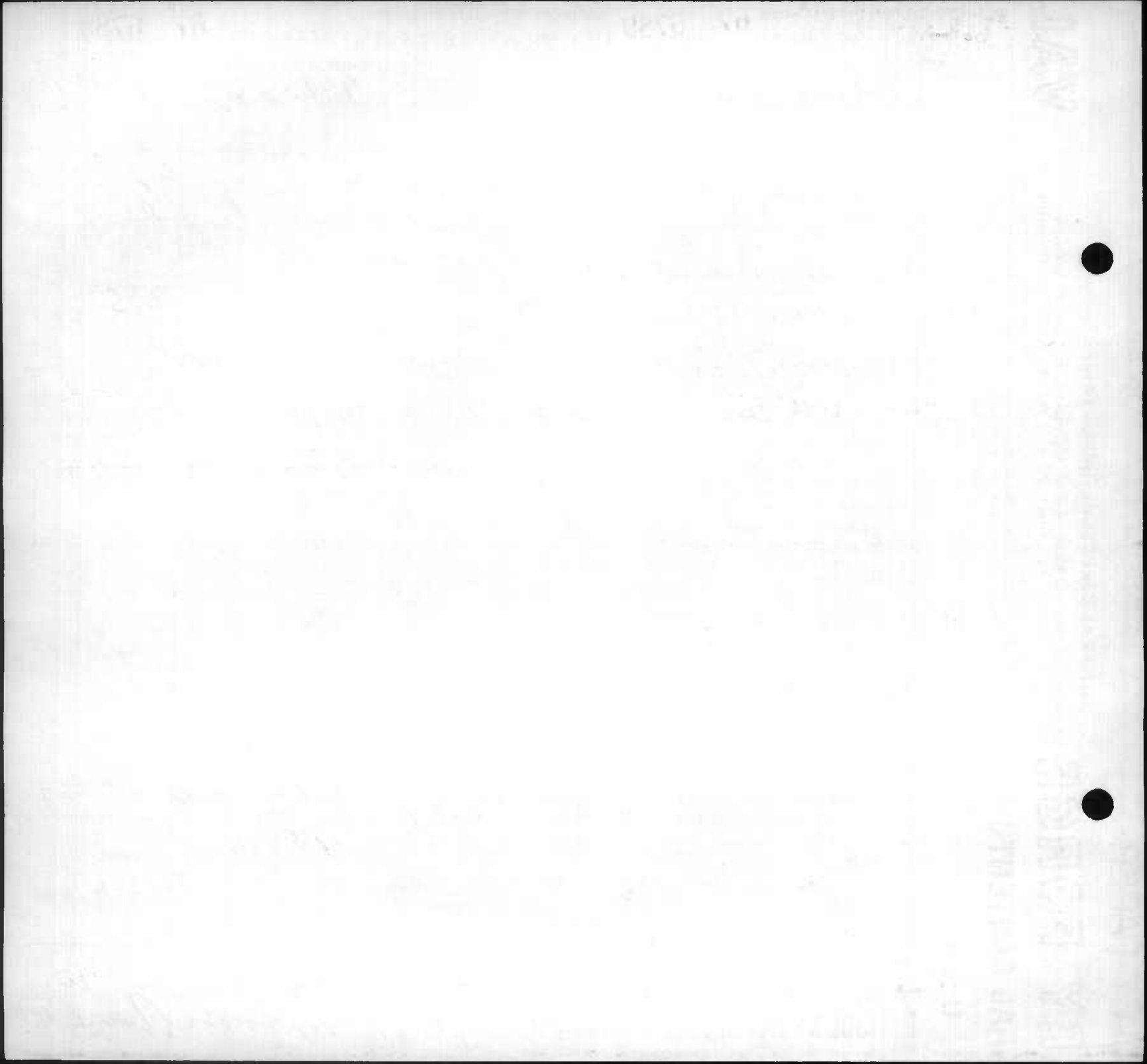
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6788		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6788	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SCARDINA, PHILIP VINCENT		JULY 9, 1967		8:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MD. 21229		A. STATE MARYLAND			
		B. COUNTY ANNE ARUNDEL			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 312 GROVE PARKWAY			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/18/06	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY AMERICAN BREWERY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN SCARDINA			14. MOTHER'S MAIDEN NAME CATHERINE (INTADIZONO) SCARDINA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			16. SOCIAL SECURITY NO. UNKNOWN		
			17. INFORMANT CATON & WILKENS AVES. 21229		
			HOSPITAL RECORDS-ST. AGNES HOSPITAL		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 + 260X		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) POSSIBLE MYOCARDIAL INFARCTION			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DIABETES MELLITUS, BRONCHOPNEUMONIA			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 6, 1967 to JULY 9, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 9, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 7-9-67	
23C. PHYSICIAN'S NAME (Type) GABRIELLA BRAUN		23D. ADDRESS BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 13-67		24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN	
24D. LOCATION (City, town, or county) (State) PITCHIL HAVEN A.A. MD		25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR GEORGE GORCE		25D. ADDRESS 4001 PITCHIL HAVEN			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6789	
CERTIFICATE OF DEATH					
BIRTH NO. 67 6789					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Logan R. Mitchell		2. DATE AND HOUR OF DEATH 7-12-67 11:20 P.M.	
3. PLACE OF DEATH BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 49 North Charles St. Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3401 Keswick Rd.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-4-20	9. AGE (In years last birthday) 46	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery man - Board of Education		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ark.	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Raymond Mitchell		14. MOTHER'S MAIDEN NAME Sarah "Lunk"			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 430 14 4597		17. INFORMANT Mary (wife)	
18. 420.1 I		CAUSE OF DEATH Mycardial Infarction		ADDRESS #2 Same	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-12-1967 to 7-12-1967 , that (I) (we) last saw the deceased alive on 7-10-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 11:20 P.M.					
23A. SIGNATURE L. Dwyer		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-12-67	
23C. PHYSICIAN'S NAME (Type) Dr. J. Ninno		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-15-67		24C. NAME OF CEMETERY or CREMATORY CEDAR BLUFF	
24D. LOCATION (City, town, or county) (State) ANNAPOLIS MD.					
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Fairman		25C. FUNERAL DIRECTOR John M. Loggins & Sons, Annapolis, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6790	
BIRTH NO. 67 6790		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Evelyn Viola Long		July 13, 1967 10:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (When deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		A. STATE Maryland B. COUNTY Carroll County	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Carrollton 36-00	
		D. STREET ADDRESS (If rural, give location) (None listed)	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 3, 1905
9. AGE (In years last birthday) 62		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY N.A.	
13. FATHER'S NAME Zachariah M. Harris		14. MOTHER'S MAIDEN NAME Bessie Viola Martin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Admission Summary		ADDRESS	
18. 720.1 I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Endocardial myocardial infarction	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ?	
		(C) Arteriosclerotic Cardiovascular Disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		UNKNOWN	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from June 29 1967 to July 13 1967 , that (I) (<u>we</u>) last saw the deceased alive on July 13 1967 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Bruce E. Cathey		23B. DATE SIGNED July 13, 1967	
23C. PHYSICIAN'S NAME (Type) Bruce E. Cathey		23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/16/67	
24C. NAME OF CEMETERY or CREMATORY Carrollton Church Cemetery		24D. LOCATION (City, town, or county) (State) Carrollton Carroll Co. MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Robert E. Taylor		ADDRESS Robert E. Taylor Jr. Westminster Md.	

Evlyn Viola Long

Union Memorial Hospital

Female White Married

Housewife N.A.

Zachariah M. Harris

No

Admission Summary

Bessie Viola Martin

Maryland

U.S.A.

March 3, 1963

(None listed)

Carrollton

Maryland, Carroll County

July 13, 1963

10:45

Arteriosclerotic Cardiovascular Disease

Yes

July 13

June 29

63

July 13

Bruce E. Cathey
Bruce E. Cathey

Union Memorial Hospital

July 13, 1963

✓

Bruce 7/16/63 Carroll County, Carroll County, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6791	
67 6791				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				3 HARRER, KATHARINE B -	
2. DATE AND HOUR OF DEATH		JULY 12 1967 4:10 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		A. STATE B. COUNTY MARYLAND, CARROLL			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) WESTMINSTER			
		D. STREET ADDRESS (If rural, give location) 130 WILLIS ST.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 7-16-91	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) CARROLL CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES W. BEACHAM			14. MOTHER'S MAIDEN NAME NELLIE SLINGHUFF		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 220-44-6659	17. INFORMANT MRS. STANFORD HOFF		ADDRESS WILLIS ST. WESTMINSTER MD.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 327.11		CAUSE OF DEATH (A) CHRONIC PULMONARY EMPHYSEMA 6 yrs (B) DUE TO (C) COR PULMONALE 3 yrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 7-10 1967 to 7-12 1967, that (I) (we) last saw the deceased alive on 7-12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Major W. Bradshaw				23B. DATE SIGNED 7-12-67	
23C. PHYSICIAN'S NAME (Type) MAJOR W. BRADSHAW M.D.				23D. ADDRESS JOHNS HOPKINS HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/15/67		24C. NAME OF CEMETERY or CREMATORY WESTMINSTER CEM.	
24D. LOCATION (City, town, or county) (State) WESTMINSTER, MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR J. S. Murphy		ADDRESS Westminster, Md. 21157			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6792 CERTIFICATE OF DEATH					Registered No. 67 6792				
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MYRTLE A. MUMMERT </div> <div> 2. DATE AND HOUR OF DEATH July 13. 1967. 4:05 am. </div> </div>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital </div> <div style="flex: 1;"> (If not in hospital or institution, give street address or location) </div> </div>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex;"> <div style="flex: 1;"> A. STATE PENNSYLVANIA - (HANOVER) </div> <div style="flex: 1;"> B. COUNTY </div> </div> 5. CITY OR TOWN (If outside city limits, write RURAL and give township) HANOVER				
6. STREET ADDRESS (If rural, give location) 233 MEADE AVE.					7. SEX Female				
8. RACE White		9. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		10. DATE OF BIRTH 3-29-98		11. AGE (In years last birthday) 69		12. If Under 1 Yr. Months: Days: Hours: Min. 4m.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY —				
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME TURVIN ECKERT					14. MOTHER'S MAIDEN NAME CORA SHAFFER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. —				
17. INFORMANT Myrtle A. Mummert					ADDRESS Hanover Pa 233 Meade Ave				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Generalized Atherosclerotic Disease with Peripheral Vascular Disease. (B) Severe Diabetic Mellitus (C) Septicemia secondary to gangrenous infected stump.				
INTERVAL BETWEEN ONSET AND DEATH 6 yrs.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —									
19A. DATE OF OPERATION July 7. 1967					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE RT. Leg				
20A. AUTOPSY? (Yes or No) —					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? —				
22. I certify that (in this hospital) attended the deceased from 6-30-1967 to 7-13-1967, that (we) last saw the deceased alive on 7-13-1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.									
23A. SIGNATURE N. H. Didizian, M.D.					23B. DATE SIGNED 7-13-1967				
23C. PHYSICIAN'S NAME (Type) NOUBAR H. DIDIZIAN,					23D. ADDRESS THE UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7/16/67				
24C. NAME of CEMETERY or CREMATORY Wt. Olver					24D. LOCATION (City, town, or county) (State) Hanover Pa York Co				
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967					25B. NAME OF REGISTRAR Robert E. Finkelman				
25C. FUNERAL DIRECTOR Wayne V. Kenworthy					ADDRESS Hanover Penna				

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6793		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6793	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NACE JAMES		2. DATE AND HOUR OF DEATH 7-13-67 7-25 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-09 D. STREET ADDRESS (If rural, give location) c/o Mount Conventance Home - 21216			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MD 3706 Antenna Rd.		5. SEX M		6. RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE		8. DATE OF BIRTH SEPT 1, 1914		9. AGE (In years lost birthday) 52 years	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDY MAN		10B. KIND OF BUSINESS OR INDUSTRY MT. CONVAL HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JAMES S. NACE, SR.		14. MOTHER'S MAIDEN NAME MARGARET STARR	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. ?		17. INFORMANT LILLIAN M. TAYLOR - PASADENA, MD	
18. 330 X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Subarachnoid haemorrhage			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Hypertension			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-10 - 1967 to 7 - 13 - 1967 , that (I) (we) last saw the deceased alive on 7 - 13 - 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anjeshi		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-13-67	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI		23D. ADDRESS Lutheran Hospital of Maryland 730 Ashlinton St. Baltimore 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/67		24C. NAME of CEMETERY or CREMATORY St. Mary's, Hampden	
24D. LOCATION (City, town, or county) Balto Md		24E. LOCATION (City, town, or county) 3900 Roland Ave, Balto Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Pub E. Fabela		25C. FUNERAL DIRECTOR Austin E. Donovan - 3818 Roland Ave	

21/10

1900-1901

21/10

11/10/1900

11/10/1900

4869.2 7 6 7 0 0 0 0 0 0 0

THE UNIVERSITY OF CHICAGO

MILITARY HISTORY

VOLUME 1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6795

BIRTH NO. 67 6795

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Katherine H. RANDOLPH

2. DATE AND HOUR PRONOUNCED DEAD

July 13, 1967

5:45. A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)46
99
Lutheran Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2706 Baker Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-28-18

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Blenza Wright

14. MOTHER'S MAIDEN NAME

Ida Handy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

John Randolph

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Carcinoma of rectosigmoid

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED20A. AUTOPSY? (Yes or No)
(Partial) Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

Partial

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

17-17-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 17 1967

Kelson Funeral Home 1348 Calhoun St.

WALLEY PONGE

WALLEY PONGE

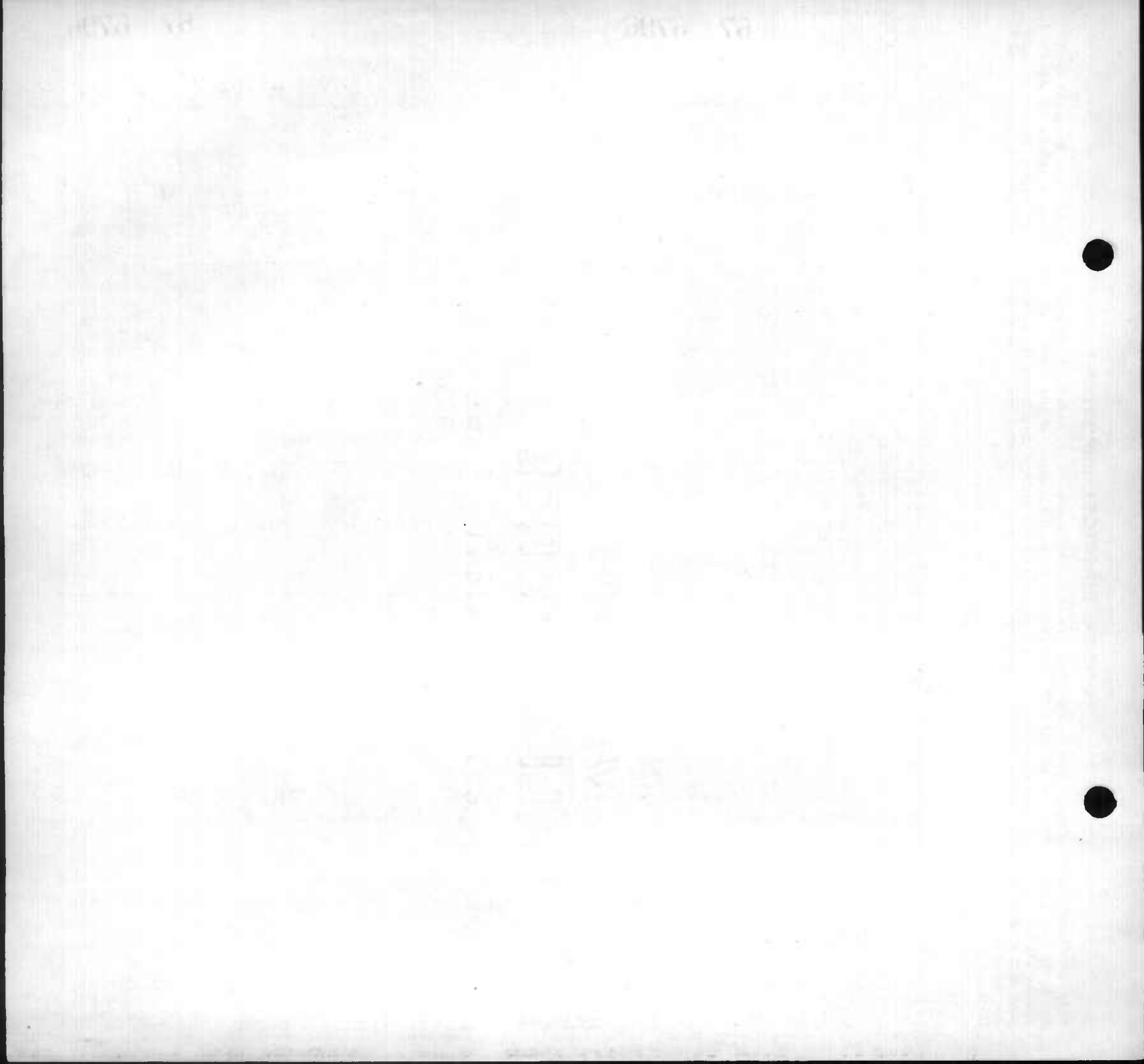
WALLEY PONGE



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6796					
<div style="display: flex; justify-content: space-between;"> 9-5010 67 6796 CERTIFICATE OF DEATH </div>															
BIRTH NO.				M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) BERNARD QUEEN				2. DATE AND HOUR OF DEATH July 14, 1967 2:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 618 Edgewood St.							
5. SEX M		6. RACE N		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 7/28/01		9. AGE (In years last birthday) 65		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement finisher				10B. KIND OF BUSINESS OR INDUSTRY Dept of Highways		11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Thomas B. Queen						14. MOTHER'S MAIDEN NAME MARY F. Johnson									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-12-4803		17. INFORMANT ADDRESS Wife - Dorothy Queen 618 Edgewood Ave									
18. CAUSE OF DEATH															
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>(A) Metastases to Brain 6 mos.</p> <p>(B) Alveolar cell Carcinoma of lungs 8 mos.</p> <p>(C)</p> </div> </div>															
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>															
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 7/14 19 67 to 7/14 19 67 , that (I) (we) last saw the deceased alive on 7/14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE Gary M. Lattin								M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/14/67					
23C. PHYSICIAN'S NAME (Type) Gary M. Lattin						23D. ADDRESS M.D. University Hospital									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-19-67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland							
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967				25B. NAME OF REGISTRAR Robert E. Taylor, MA				25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.							



1
W-452

67. 6797. BALTIMORE CITY HEALTH DEPARTMENT

67. 6797. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print)		CHARLES LEROY WILLIAMS		2. DATE AND HOUR PRONOUNCED DEAD July 13, 1967 11:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 00 129 N. Fulton Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 129 N. Fulton Avenue	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married Sep.	8. DATE OF BIRTH June 6, 1919	9. AGE (In years last birthday) 48	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10B. KIND OF BUSINESS OR INDUSTRY Transfer		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Charles A. Williams		14. MOTHER'S MAIDEN NAME Anna Binkney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-10-1650		17. INFORMANT ADDRESS Dorothy Johnson 1814 W. Lexington St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 581.0 I Left bronchopneumonia DUE TO fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (Partial)		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> Partial		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 13, 1967	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE July 18, 1967		23C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk. Arbutus Md.	
24A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		24B. NAME OF REGISTRAR Robert E. Fadden		24C. FUNERAL DIRECTOR Williams Funeral Home 319 N. Schaefer St.	
				ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67. 6798					REGISTERED NO. 67. 6798				
BIRTH NO.					DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) JACOBS, CORNELIA					2. DATE AND HOUR OF DEATH 7/14/67 2:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE					A. STATE MD. B. COUNTY 28-03				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
D. STREET ADDRESS (If rural, give location) 4153 Fairview Ave									
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/16/20	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Richard Matthews			14. MOTHER'S MAIDEN NAME Pauline Matthews						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Julius Jacobs - 4153 Fairview Ave				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 170 X1			CAUSE OF DEATH Breast Carcinoma with Pulmonary metastases + possibly Brain metastases			INTERVAL BETWEEN ONSET AND DEATH 3 years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO CARDIO-RESPIRATORY FAILURE						
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Intestinal Obstruction			17 days			
19A. DATE OF OPERATION 6/27/67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from July 1st 1967 to July 14 1967 , that (I) (we) last saw the deceased alive on July 14th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE F. Martinez					M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 14, 1967		
23C. PHYSICIAN'S NAME (Type) FERDINAND MARTINEZ					23D. ADDRESS SINAI HOSPITAL OF BALTIMORE				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-19-67		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Theresa B. Oden		ADDRESS Baltimore, Md			

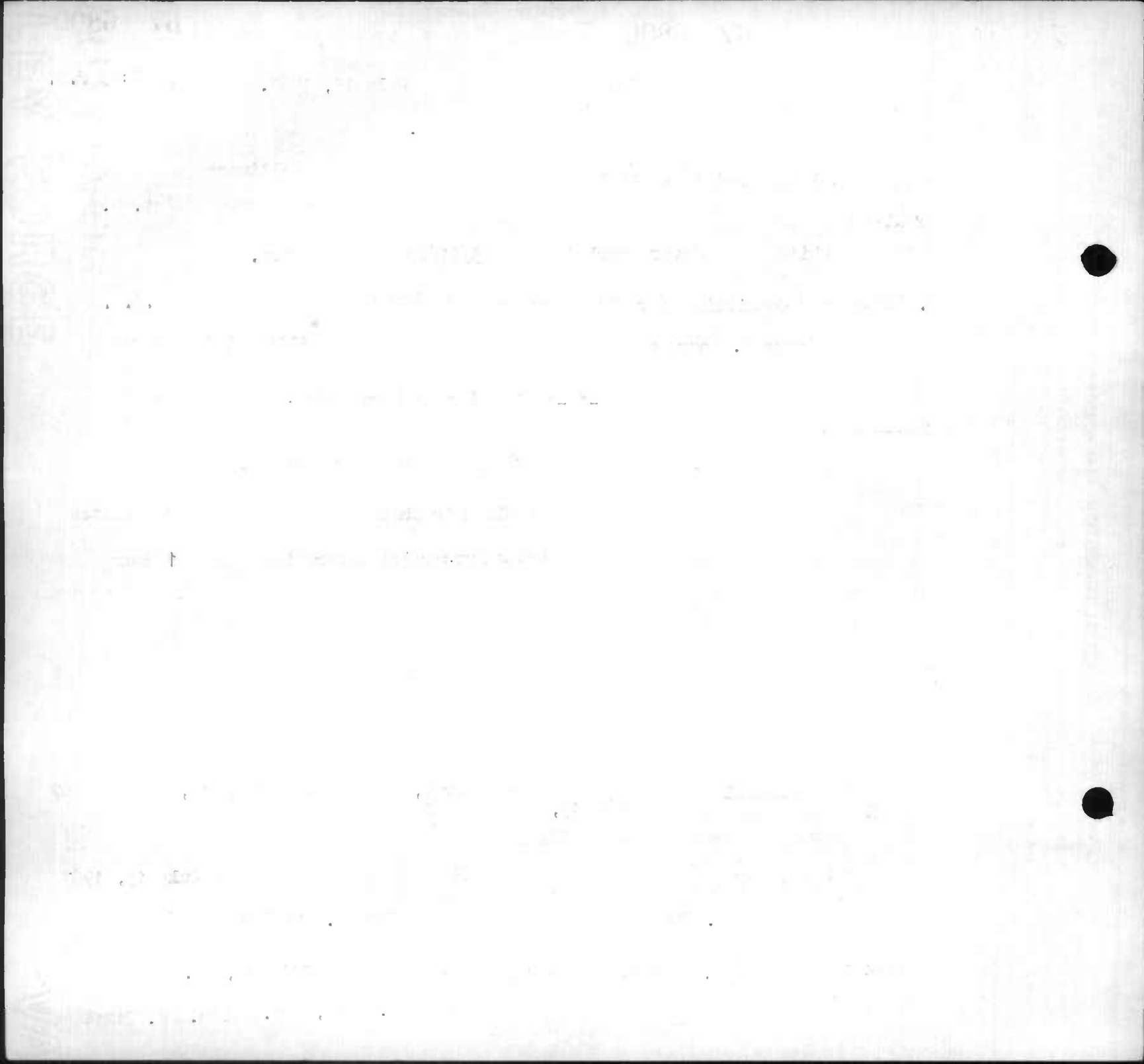
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6799		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6799	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM FEWSTER (WM. FEWSTER)		2. DATE AND HOUR OF DEATH 7/13/67 7:50 pm 7:50P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION The Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. #21224		D. STREET ADDRESS (If rural, give location) 8028 Gough St. #21224 005			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-5-07	9. AGE (In years last birthday) 60 60	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUREAU OF SANITATION		10B. KIND OF BUSINESS OR INDUSTRY CITY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William FEWSTER		14. MOTHER'S MAIDEN NAME Margaret Quick	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT BCM RECORDS: 4940 Eastern Avenue Baltimore, Maryland #21224	
18. 345X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary tract infection.		CAUSE OF DEATH (A) Respiratory failure due to (1) Multiple sclerosis — 25 years (B) (2) Bronchitis — 15 days (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-2-1967 to 7-13-1967 , that (I) (we) last saw the deceased alive on 7-13-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Zachary Grossman M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-13-67	
23C. PHYSICIAN'S NAME (Type) ZACHARY GROSSMAN		23D. ADDRESS 4940 Eastern Avenue Balto., Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-17-67		24C. NAME OF CEMETERY or CREMATORY PARKWOOD Cem.	
24D. LOCATION (City, town, or county) (State) BALTO., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Jeffery E. Fisher - 2334 Jefferson St.		ADDRESS			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6800	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 6800 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Ted Andrews 2. DATE AND HOUR OF DEATH July 15, 1967. 2:25 P.M. </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 700 Park Avenue Apt. D.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED Never Married	8. DATE OF BIRTH 5/21/07	9. AGE (In years lost birthday) 60 yrs.	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Md. State Road Commission (Traffic Checker)			11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Cyrus M. Andrews			14. MOTHER'S MAIDEN NAME Willi Hollingsworth		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 064-18-1992	17. INFORMANT ADDRESS Miss Kathryn Andrews (Same)		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Peripheral Vascular Collapse ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cardiogenic Shock Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 40 minutes 1 Hour					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) observed attended the deceased from October 7, 1962 to July 15, 1967 , that (I) X last saw the deceased alive on July 15, 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) XX (did) observe view the body after death.					
23A. SIGNATURE Leonard H. Flax M.D.				23B. DATE SIGNED July 15, 1967	
23C. PHYSICIAN'S NAME (Type) Leonard H. Flax M.D.				23D. ADDRESS 2702 N. Charles Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/19/67.		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECD BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	



BIRTH NO. **6801** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6801**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)**ROBERT L. WILLET**

2. DATE AND HOUR PRONOUNCED DEAD

July 13, 1967**6:30 p.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**MARYLAND GENERAL HOSPITAL D.O.A.**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4433 Shamrock AVE

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**married**

8. DATE OF BIRTH

Aug. 21, 19129. AGE (In years
last birthday)**54**If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Senior Sanitarian**

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Pennsylvania12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Leo Willet

14. MOTHER'S MAIDEN NAME

Bertha I. Miller15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**no**16. SOCIAL
SECURITY NO.**192-10-1090**

17. INFORMANT

Mrs. Verle Willet

ADDRESS

same18. **970.2**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Acute Barbiturate intoxication**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO(C)
DUE TOII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)**Home**21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)**4433 Shamrock**21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

7 13 67 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingestion of barbiturates

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)**Russell S. Fisher, M.D.**CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 14, 196723A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

7/17/67

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 17 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

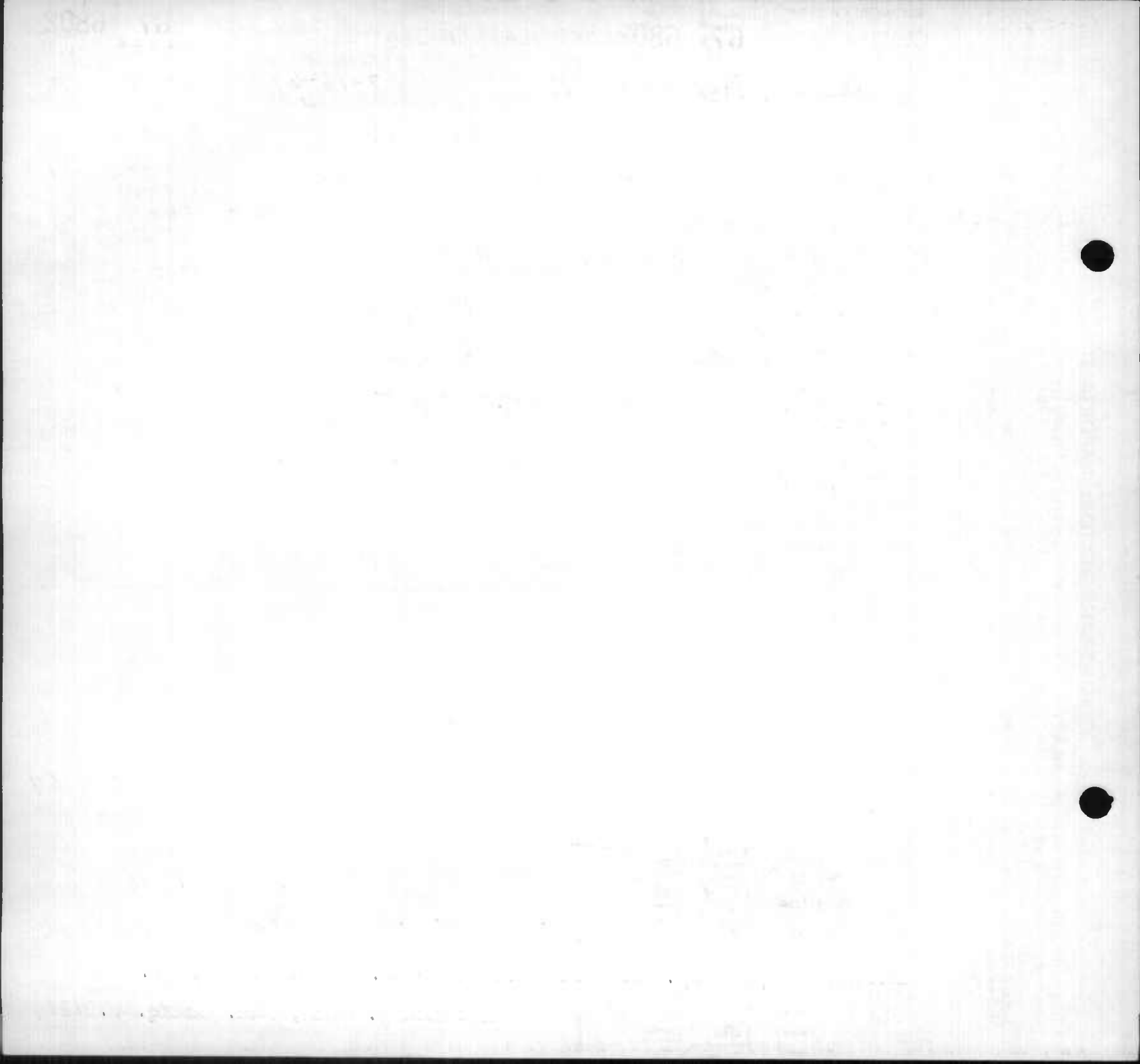
G-320

BALTIMORE CITY HEALTH DEPARTMENT

67 6802 CERTIFICATE OF DEATH

Registered No. 67 6802

BIRTH NO.		67 6802		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Gates, Margaret M				2. DATE AND HOUR OF DEATH 7-16-67 11²⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21206			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hospital 49				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-01			
D. STREET ADDRESS (If rural, give location) 4113 Echodale Road AVE							
5. SEX F	6. RACE Wh	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 11-2-1900	9. AGE (In years lost birthday) 66 yrs	10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Schubert, Charles				14. MOTHER'S MAIDEN NAME Burke, Alberta			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 813-05-5475		17. INFORMANT chart		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 578X1 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) UREMIA				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. G.I. Bleeding -							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-28-1967 to 7-16-1967 , that (I) (we) last saw the deceased alive on 7-16-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Ruck				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-16-67	
23C. PHYSICIAN'S NAME (Type) Friedman, Marion				23D. ADDRESS 5211 Harford Road Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/20/67		24C. NAME of CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 6803		67 6803		6 P.M.	
BIRTH NO. M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) ALMIRA ALGER			2. DATE AND HOUR OF DEATH July 14, 1967		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 810 Venable Avenue			A. STATE MD B. COUNTY 810 VENABLE AVE		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Maryland		
			D. STREET ADDRESS (If rural, give location) 9-03		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-23-1899	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Laurens, New York
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Emmett Stanton		
14. MOTHER'S MAIDEN NAME Ella Harrison			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 072-70-7418B			17. INFORMANT Frederick E. Alger		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 175.01 Adeno Carcinoma of Ovary with generalized metastasis			INTERVAL BETWEEN ONSET AND DEATH 3 months		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPRX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21G. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		21H. SIGNATURE Charles B. Marek MD		21I. DATE SIGNED	
21J. PHYSICIAN'S NAME (Type) Charles B. Marek		21K. ADDRESS 3300 The Planted		21L. DATE SIGNED	
21M. BURIAL CREMATION, REMOVAL (Specify) Burial		21N. DATE 7/17/67		21O. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park	
21P. LOCATION Balto. Md		21Q. DATE REC'D BY HEALTH DEPT. JUL 17 1967		21R. NAME OF REGISTRAR Robert E. Farkner	
21S. FUNERAL DIRECTOR Leonard J. Ruck Inc.		21T. ADDRESS 5305 Harford Rd.		21U. DATE SIGNED	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 6804 CERTIFICATE OF DEATH					Registered No. 67 6804					
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 6804</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) EMMA PAULINE HARTMAN</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 7/13/1967 5:45 P.M.</p> </div> </div>										
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GEN. HOSPITAL</p>					<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A, STATE MD B, COUNTY</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21206</p> <p>D. STREET ADDRESS (If rural, give location) 4802 MIDLINE Rd. 21206</p>					
<p>5. SEX F</p>		<p>6. RACE W</p>		<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow</p>		<p>8. DATE OF BIRTH 11/28/1872</p>		<p>9. AGE (In years last birthday) 94</p>		
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>				<p>10B. KIND OF BUSINESS OR INDUSTRY —</p>		<p>11. BIRTHPLACE (State or foreign country) MD.</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>		
<p>13. FATHER'S NAME Julius Haupt.</p>					<p>14. MOTHER'S MAIDEN NAME ?</p>					
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p>				<p>16. SOCIAL SECURITY NO. 215-56-1237-J1</p>		<p>17. INFORMANT ADDRESS R. ROSENTHAL, M.D. N. CHARLES Hosp.</p>				
<p>18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH ARTERIOSCLEROTIC HEART DISEASE</p> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CORONARY insufficiency</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>										
<p>19A. DATE OF OPERATION 0</p>			<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>			<p>20A. AUTOPSY? (Yes or No) no</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>			<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>				
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>			<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work</p>			<p>21F. HOW DID INJURY OCCUR?</p>				
<p>22. I certify that (I) (this hospital) attended the deceased from 7/12/1967 to 7/13/1967 that (I) (we) lost saw the deceased alive on 7/13/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>										
<p>23A. SIGNATURE Robert Rosenhoff</p>					<p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>			<p>23B. DATE SIGNED 7/13/67</p>		
<p>23C. PHYSICIAN'S NAME (Type) C. ARANAGA</p>					<p>23D. ADDRESS North Charles General Hospital</p>					
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>			<p>24B. DATE July 17, 1967</p>			<p>24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery</p>			<p>24D. LOCATION (City, town, or county) (State) Baltimore Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967</p>			<p>25B. NAME OF REGISTRAR Robert E. Jenkins</p>			<p>25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.</p>			<p>ADDRESS Baltimore Md.</p>	

Julius Haupt.

B-650

67. 6805

BALTIMORE CITY HEALTH DEPARTMENT

67. 6805

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Pratt W. Brown				2. DATE AND HOUR PRONOUNCED DEAD July 15, 1967 3:20 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1212 McCulloh Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1212 McCulloh Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH May 31-1923	9. AGE (In years last birthday) 42	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Howard Brown				
14. MOTHER'S MAIDEN NAME Jeannette Wallace			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service) YES				
16. SOCIAL SECURITY NO.			17. INFORMANT Alma Jones 3608 Marmora Ave				
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty Alteration of Liver (A) DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Partial							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/15/67							
23A. BURIAL CREMATION, REMOVAL (Specify) Buried		23B. DATE 7-18-67		23C. NAME OF CEMETERY or CREMATORY Baltimore Nat Cem		23D. LOCATION (City, town, or county) (State) Baltimore Md	
24A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		24B. NAME OF REGISTRAR Robert E. Feltz, M.D.		24C. FUNERAL DIRECTOR Chas. O. Wilson Beauty Shop		ADDRESS	

1
N-252

67 6806

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6806

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

TYLER NICKENS

2. DATE AND HOUR PRONOUNCED DEAD

July 12, 1967

7:45 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

42
99 Sinai Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-17

D. STREET ADDRESS (If rural, give location)

3037 Oarley Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Sept 13 - 1900

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF
WHAT COUNTRY

USA

13. FATHER'S NAME

John Nickens

14. MOTHER'S MAIDEN NAME

Emilee Woods

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Amelia Lee 1721 N Carey St

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion

resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-24-67

23C. NAME OF CEMETERY or CREMATORY

Baltimore Cat

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 17 1967

Robert E. Farley, M.D.

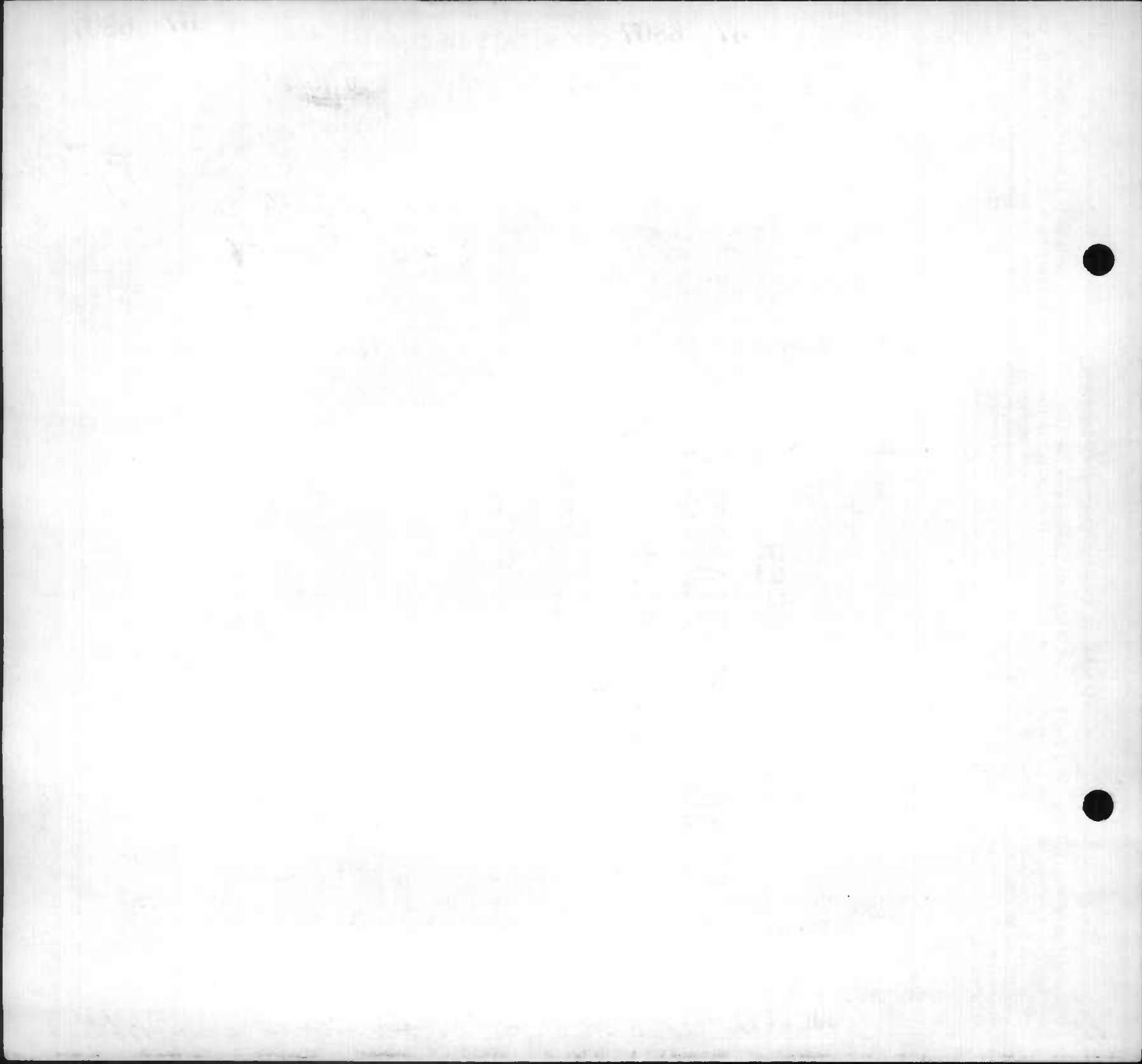
Choy O Wilson, M.D. 1001 Brantley

LIBRARY
UNIVERSITY OF CALIFORNIA
LIBRARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6807	
BIRTH NO. 67 6807		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDMONDS, Elizabeth		2. DATE AND HOUR OF DEATH 7/14/67 2:15 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hosp.		A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give town) BALTIMORE D. STREET ADDRESS (If rural, give location) 505 Myrtle Ave			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 2/14/16	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
13. FATHER'S NAME EDMONDS, William		14. MOTHER'S MAIDEN NAME MOTRE CORNELIA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MOTRE, ALBERT 2613 W Farmmount Ave	
18. 331 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage Arterial hypertension ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9:30 AM July 14 1967 to 2:15 PM July 14 1967 , that (I) (we) last saw the deceased alive on July 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ricardo Garcia		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) RICARDO GARCIA		23D. ADDRESS 4034 The Glanada Bldg			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-18-67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cmt	
24D. LOCATION (City, town, or county) (State) Balto Md		25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS George Wilson 1000 Broadway N.E.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No.	
BIRTH NO.		67 6808		67 6808			
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)		Lannie Maddox		2. DATE AND HOUR OF DEATH		July 7 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
002025 W. Lanvale St.				Maryland		Baltimore 16-04	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		C		Married		April 2 1920 49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Reisterstown Md		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
William A. Stewart		Lannie Griffin		No			
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
John T. Maddox		Same		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Carcinoma of Ovary 6 weeks Widespread metastasis to liver, peritoneum, etc.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
6/16/67		Carcinoma		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
No		No		No			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/6/67 to 7/7/67, that (I) (we) last saw the deceased alive on 7/6/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Allen Kleiman				7/15/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ALLEN KLEIMAN				1115 N CALVERT ST BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or County) (State)	
Burial		7-10-67		St Luke Cat		Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 17 1967		Robert E. Faldut		Choyd W. Ileson 1000 Broadway Ave			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6809	
67 6809				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Emma Dial</i>				July 14, 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>2819 Presby St</i>		(If not in hospital or institution, give street address or location)		B. COUNTY <i>Baltimore</i>	
		C. CITY OR TOWN <i>Maryland 15-06</i>		(If outside city limits, write RURAL and give township)	
		D. STREET ADDRESS <i>2819 Presby St</i>		(If rural, give location)	
5. SEX <i>Female</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>Sept 20, 1896</i>	9. AGE (in years last birthday) <i>70</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>J. Ben Weldon</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Orr</i>	
15. Was deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Carole Barron</i>	
18. <i>420.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>A. S. H. D. ; H. C. V. D. ; Congestive Failure with decompensation</i>		6 months +	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>N/A</i>					
19A. DATE OF OPERATION <i>N/A</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>N/A</i>		20A. AUTOPSY? (Yes or No) <i>N/A</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>N/A</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>N/A</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>N/A</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>N/A</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While Work <input type="checkbox"/> <i>N/A</i>		21F. HOW DID INJURY OCCUR? <i>N/A</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 10, 1967</i> to <i>June 22, 1967</i> , that (I) (we) last saw the deceased alive on <i>June 22, 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <i>July 14, 1967 10:45 A.M.</i>					
23A. SIGNATURE <i>J. Uthman Ray, Jr.</i>				23B. DATE SIGNED <i>7/17/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Uthman Ray, Jr., M.D.</i>				23D. ADDRESS <i>2225 West North Avenue 21216</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-18-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Adelphi Cent</i>	
24D. LOCATION <i>Baltimore Md</i>		24E. NAME OF REGISTRAR <i>Robert E. Johnson</i>		24F. FUNERAL DIRECTOR <i>Robert E. Johnson</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 17 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Robert E. Johnson</i>	

1880 - 1881

1881 - 1882

1882 - 1883

1883 - 1884

1884 - 1885

0-8100
S-162

67. 6810

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6810

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)PADDY O' SHEA
JAMES VINCENT SPARKS

2. DATE AND HOUR PRONOUNCED DEAD

7-5-67

12:05 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

36 FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1419 W. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

4/4/20 47

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MERCHANT SEAMAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

TENN.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Wm. ROBT. SPARKS

14. MOTHER'S MAIDEN NAME

LULA LONG

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; if yes, give war or dates of service)

YES

WW II

16. SOCIAL
SECURITY NO.369-36-4212
410-16-4315

17. INFORMANT

ADDRESS

MRS. HAZEL RYDER 2309 FOSTER AVE.

18. E900.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Craniocerebral injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

and multiple fractures of ribs

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1419 W. Baltimore Street 19-03

21D. TIME
OF INJURY
(APPROX.)

(Month)

6

(Year)

26 '67

(Day)

3:30 PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Fell down steps

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

J. P. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

7-5-67

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-12-67

23C. NAME OF CEMETERY or CREMATORY

BALTO. CEMETERY

23D. LOCATION

(City, town, or county)

BALTIMORE

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 17 1967

R. E. Fisher

RAYMOND L. KACZOROWSKI 2525 FLEET ST.

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

[Illegible Signature]

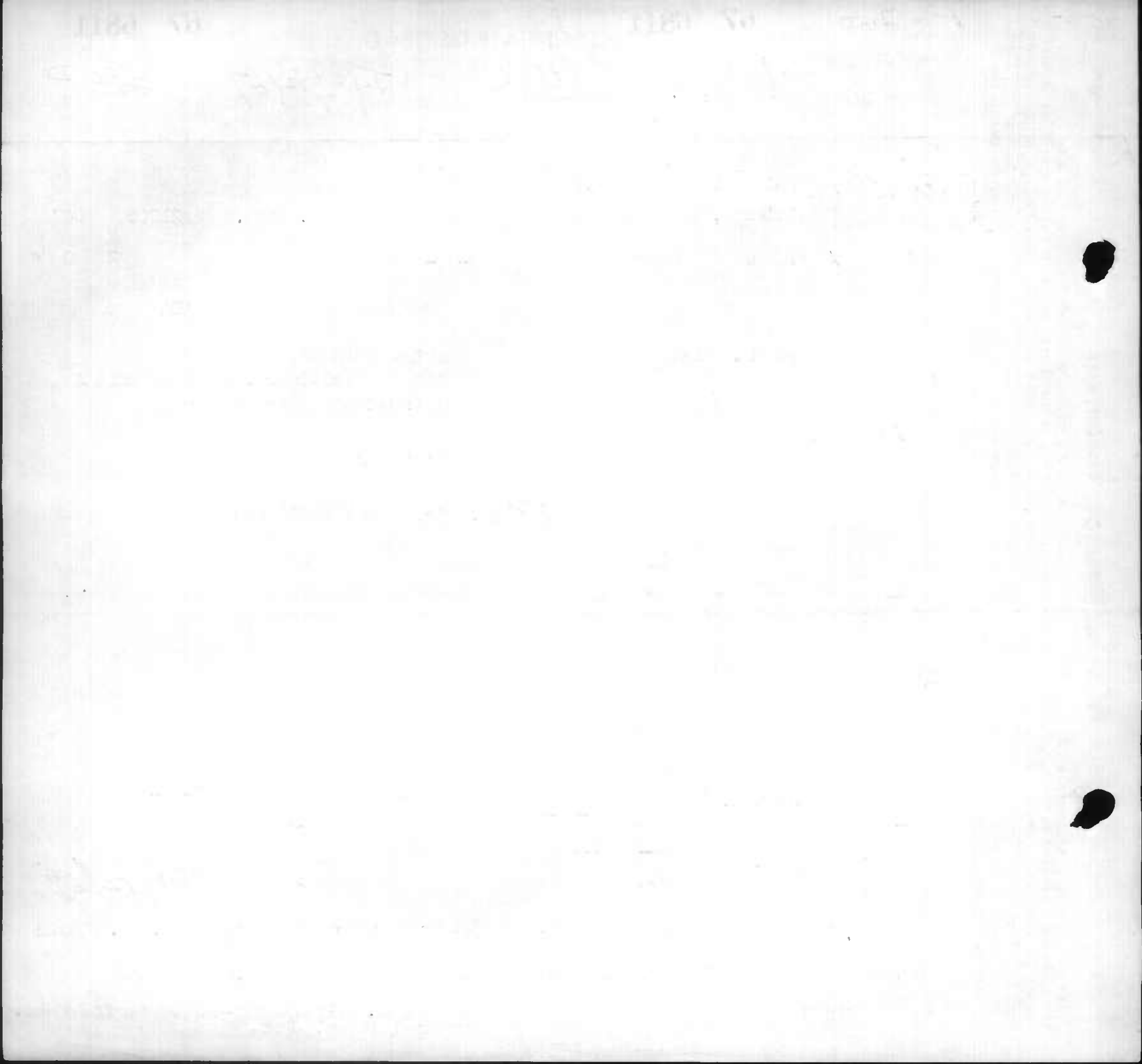
[Illegible Title]

Approved: [Illegible Signature]

[Illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

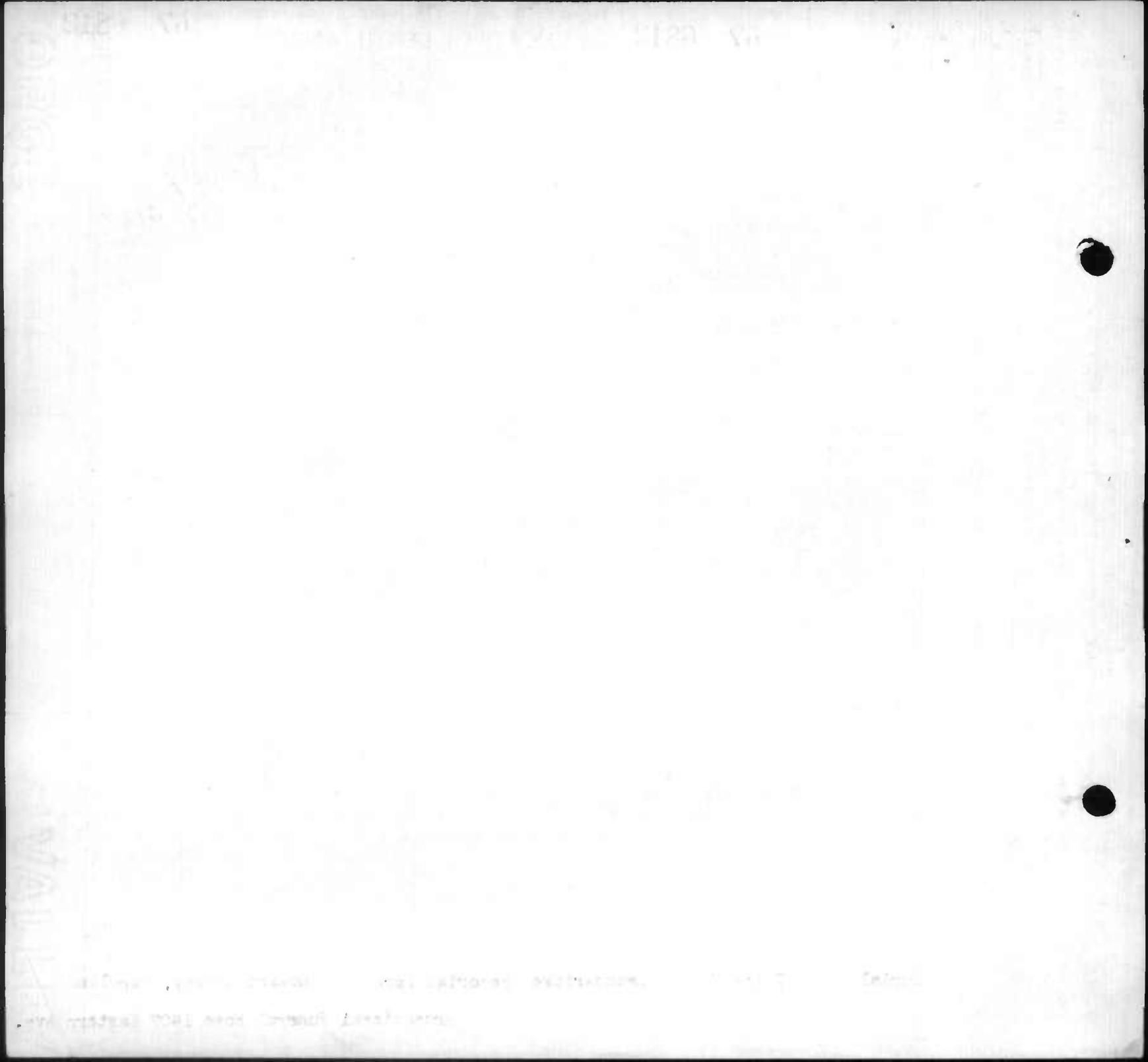
F-260-67 6811				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6811 4	
BIRTH NO. 267-14590				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BABY BOY FISHER FISHER, B. Boy (Toshiko)		JULY 12/67 3:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland #21224				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				5209 Moravia Rd. Apt. G #21206 007			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		White		Never married		7-12-67	
9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
						2 0	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Maryland				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Bernard L. Fisher				Toshiko Nakamura			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				None		Baltimore, Maryland #21224	
18. 762.51				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) APHYXIA			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B) EXTREME PREMATURITY			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO			
II				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7-12-67 19 to 7-12-67 19, that (I) (we) last saw the deceased alive on 7-12-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
D. Mayman						July 12/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
D. Mayman				M.D. 4940 Eastern Avenue Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/17/67		Balto. Nat'l Cem.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 17 1967		Robert E. Fisher		Robert C. Altenburg-6009 Harford Rd. Funeral Home, Inc.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6812	
BIRTH NO. 67 6812		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY STREB			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH July 12, 1967 4:00 PM			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home & Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore County 53-00			
		D. STREET ADDRESS (If rural, give location) 180 ORVILLE RD 21221			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-18-01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JACKSON CORDOR		
14. MOTHER'S MAIDEN NAME MARTHA HARR			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 220 46 8365			17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO ACUTE MYO CARDIAC INFARCTION 7 DAYS			
(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 11, 1967 to July 12, 1967 , that (I) (we) last saw the deceased alive on 4:00 p.m. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B.C. Veneracion Jr. M.D.				23B. DATE SIGNED July 12, 1967	
23C. PHYSICIAN'S NAME (Type) VENERACION JR. M.D.				23D. ADDRESS CHURCH HOME HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/67		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park	
24D. LOCATION (City, town, or county) Howard County, Maryland		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Brusdzinski Funeral Home 1407 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6813	
BIRTH NO. 67 6813		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) MARGUERITE E. BLAKE		2. DATE AND HOUR OF DEATH 7/16/67 1 1³⁰ P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 3333 N. Charles St.		A. STATE Maryland B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3333 N. Charles St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-23-78	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Bernard N. Baker		14. MOTHER'S MAIDEN NAME Elizabeth E. Livesey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 550-14-1556D		17. INFORMANT ADDRESS Thomas B. Harrison Balto., Md.	
18. 334X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Generalized & Cerebral Arteriosclerosis - years (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 48 to July 16 19 67 , that (I) (we) last saw the deceased alive on July 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE Walter B. Buck M.D.				23B. DATE SIGNED 7/16/67	
23C. PHYSICIAN'S NAME (Type) WALTER B. BUCK M.D.				23D. ADDRESS 18 E. EAGER 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7-17-67		24C. NAME of CEMETERY or CREMATORY Greenmount	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	

1998

FUNERAL DIRECTOR: IMPORTANT

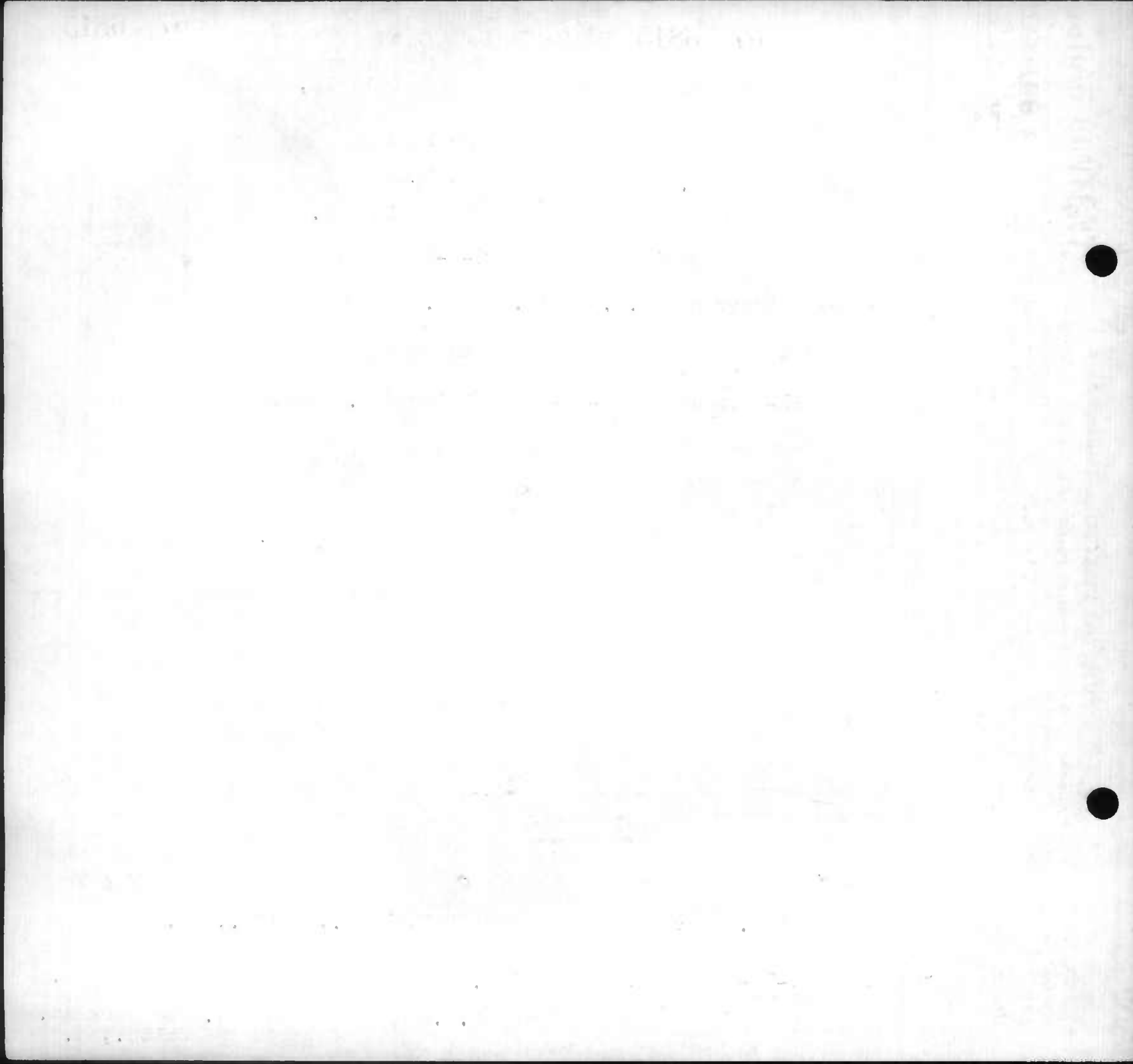
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6814	
BIRTH NO. 67 6814					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) ETHEL M. SCHNEIDER			2. DATE AND HOUR OF DEATH 7-16-67 8:10 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION Memorial HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-09 D. STREET ADDRESS (If rural, give location) 1655 KINGSWAY SQUARE		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 10-18-82	9. AGE (In years last birthday) 84	10. Under 1 Yr. Months: Days 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Ellis COLEMAN		
14. MOTHER'S MAIDEN NAME Josephine A. Button			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 218-0727710			17. INFORMANT ELEANOR RUGEMER		
18. ADDRESS 1650 KINGSWAY SQUARE			19. INTERVAL BETWEEN ONSET AND DEATH		
20. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Myocardial infarction (B) Atherosclerotic coronary disease (C) w.k.w.					
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II					
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 7-10-67 19 to 7-16-67 19, that (I) (we) last saw the deceased alive on 7-16 19 67 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Frank Palmisano M.D.			23B. DATE SIGNED 7-16-67		23C. PHYSICIAN'S NAME (Type) FRANK S. PALNISANO, JR. M.D.
23D. ADDRESS THE UNION MEMORIAL HOSPITAL			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7-19-67		24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Parkville Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 67 6815	
BIRTH NO. 67 6815		CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Isadore Francis Gagnon				2. DATE AND HOUR OF DEATH July 15, 1967 5:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5304 Leith Rd.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5304 Leith Rd.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 7-3-1908	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months: Days 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector-Engineering U.S. Gov't.				10B. KIND OF BUSINESS OR INDUSTRY Mass.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Amedee Gagnon				14. MOTHER'S MAIDEN NAME Ann Harris			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11- Korean		16. SOCIAL SECURITY NO. 015-09-3685		17. INFORMANT Winifred H. Gagnon		ADDRESS Above	
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Smoking Diabetes & Lung				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 12 1967 to July 15 1967, that (I) (we) last saw the deceased alive on July 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Paul M. Byerly				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-17-67	
23C. PHYSICIAN'S NAME (Type) Paul M. Byerly				23D. ADDRESS 5820 York Rd., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-19-67		24C. NAME OF CEMETERY or CREMATORY National (Balto.)		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

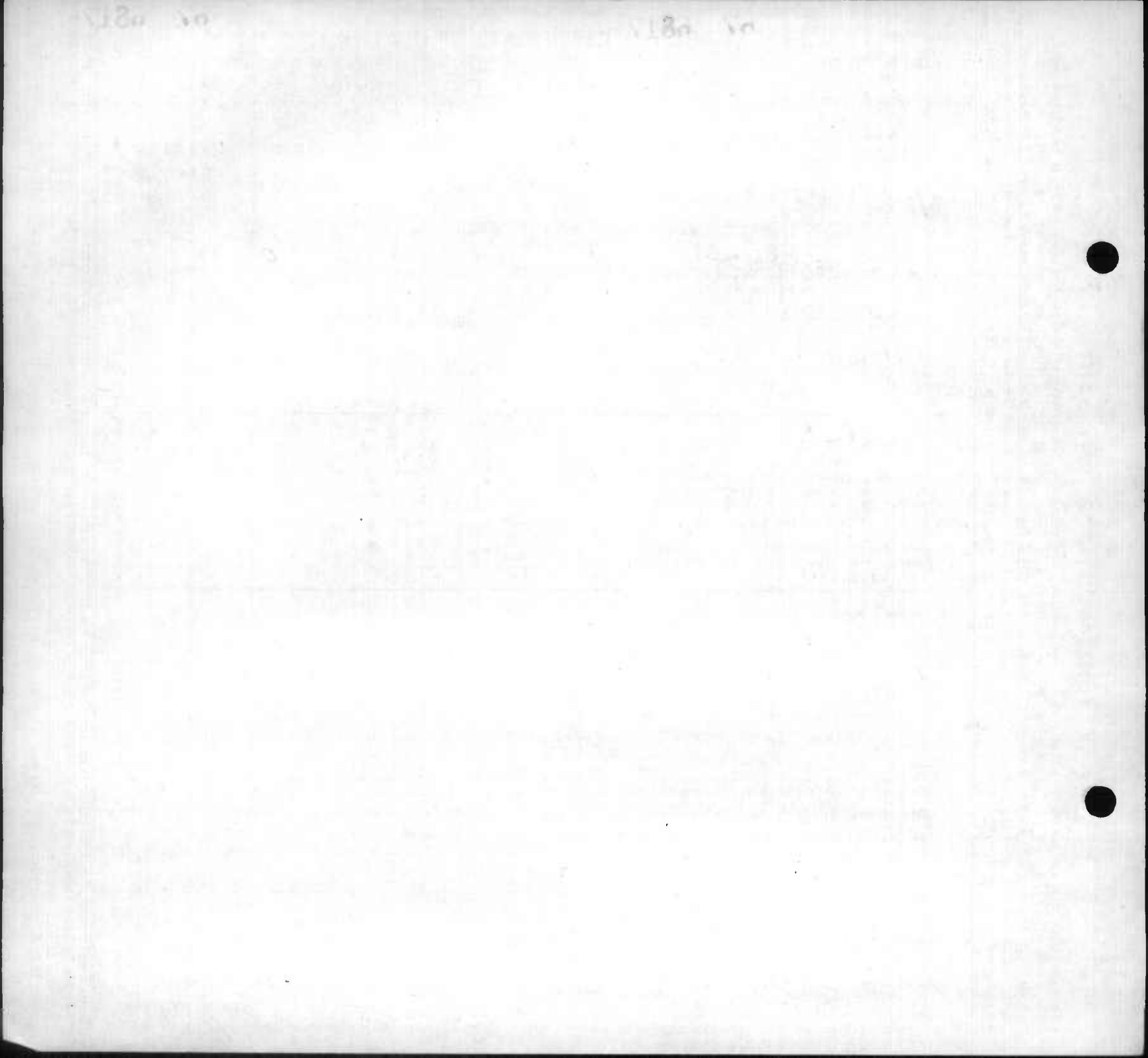
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6816	
BIRTH NO. 67 6816		CERTIFICATE OF DEATH		67 6816	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NORMAN L. Van ASDLEN		2. DATE AND HOUR OF DEATH 7/15/67 at 2:30 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 48		A. STATE Md.		B. COUNTY	
5. SEX MALE		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 12/1/85		9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-MACHINIST	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME HARPER Van ASDLEN	
14. MOTHER'S MAIDEN NAME LAURA WHEELER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No unknown		16. SOCIAL SECURITY NO. 212-01-4091	
17. INFORMANT LESTER Van ASDLEN		ADDRESS Same		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO Shock		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO Myocardial infarction ? 30 min.			
ANTECEDENT CAUSES		(C) DUE TO ASCVD			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Congestive heart failure			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19A. DATE OF OPERATION		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/3 1967 to 7/15 1967.		23A. SIGNATURE A.N. MAURIDIS		23B. DATE SIGNED 7/15/67	
23C. PHYSICIAN'S NAME (Type) A.N. MAURIDIS		23D. ADDRESS Md. GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-18-67		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION Parkville		24E. LOCATION (City, town, or county) Parkville		24F. LOCATION (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 17 1967		25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6817				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6817	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOYNER MR JOHN				2. DATE AND HOUR OF DEATH 7/11/67 9:35 P			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MGH Maryland General				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 9-05			
D. STREET ADDRESS (If rural, give location) 1407 Montpelier St.				5. SEX M 6. RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M			
8. DATE OF BIRTH 10/30/16 9. AGE (In years last birthday) 50				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) NC	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME HOWARD JOYNER			
14. MOTHER'S MAIDEN NAME Costella WATSON				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 238-16-0720				17. INFORMANT Mary Joyner 1407 Montpelier St.			
18. 592X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHRONIC RENAL DISEASE - PULMONARY EDEMA.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ANEMIA							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/27 1967 to 7/11 1967 , that (I) (we) last saw the deceased alive on 7/11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ann R Wilke				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/11/67	
23C. PHYSICIAN'S NAME (Type) ANN R WILKE				23D. ADDRESS MGH			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/14/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967				25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Arkington Phillips 1727 N. Monmouth	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6818	
BIRTH NO. 67 6818		CERTIFICATE OF DEATH		Registered No. 67 6818	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Kearney Lindsay		2. DATE AND HOUR OF DEATH 7/13/1967 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2124 Mt. Royal Ter.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 14-02		D. STREET ADDRESS (If rural, give location) 1707 MC Cullah St.	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/4/1876	9. AGE (In years last birthday) 91	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Minister		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Jim Lindsay		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-5876A		17. INFORMANT Edna Matthews	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio Vascular Disease		CAUSE OF DEATH		ADDRESS 2124 Mt. Royal Ter.	
INTERVAL BETWEEN ONSET AND DEATH one year		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3/24 19 66 to 7/13 19 67, that (I) (we) last saw the deceased alive on 7/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ralph W. Reckling		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/14/67	
23C. PHYSICIAN'S NAME (Type) Ralph W. Reckling		23D. ADDRESS 1401 A Edmondson Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/67		24C. NAME of CEMETERY or CREMATORY Archutus Mem. Ch. Baltimore Md.	
24D. LOCATION (City, town, or county) Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Main St.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6819		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6819	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Chester Pittman		2. DATE AND HOUR OF DEATH 7/15/67 1:30 A			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) the Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 2142 W. North Ave					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 1/18/35	9. AGE (In years lost birthday) 32 yr	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Oswell Pittman		14. MOTHER'S MAIDEN NAME SARAH Chapman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother ADDRESS Fairmount North Carolina	
18. 593X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CARDIAC ARREST + Resp. ARREST (B) Severe hypertension (C) Severe Renal Failure			
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilat. Nephrectomy					
19A. DATE OF OPERATION 7/7/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe hypertension		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/1 19 67 to 7/15 19 67 , that (I) (we) last saw the deceased alive on 7/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James B. Brayton		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/15/67	
23C. PHYSICIAN'S NAME (Type) JAMES B. BRAYTON		M.O. ADDRESS Johns Hopkins Hospital BALTIMORE MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7/18/67		24C. NAME OF CEMETERY OR CREMATORY Snow Hill	
24D. LOCATION (City, town or county) (State) Lumberton N.C.					
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR McMillan Funeral Home ADDRESS Lumberton N.C.	

OSWELL PITTMAN
LABORER

SEVERE RURAL ILLNESS
SEVERE HYPERSTENSION
CHRONIC ARTERIO SCLEROSIS

1/16/17 SEVERE HYPERSTENSION
B.LAT. HYPERSTENSION

JAMES B. BRIDGES
JAMES B. BRIDGES

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1/1/17

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1/1/17

Released by Dr. Polomino from M.E.'s Office
ON APPROVAL
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6820	
BIRTH NO. 67 6820		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Delbert Crosby</i>		2. DATE AND HOUR OF DEATH <i>7/16/67</i> <i>3:49 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i>		D. STREET ADDRESS (If rural, give location) <i>1239 N. DECKER AVE.</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGROID</i>	7. MARRIED, NEVER MARRIED <i>SEPARATED</i>	8. DATE OF BIRTH <i>2-7-21</i>	9. AGE (In years lost birthday) <i>46</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>STEVEDOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>WATERFRONT</i>		11. BIRTHPLACE (State or foreign country) <i>SPARROWS POINT, MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>JOHN DAVIS</i>		14. MOTHER'S MAIDEN NAME <i>ARNETTA CROSBY</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>ARNETTA C WALKER</i>	
				ADDRESS <i>307 LENNOX AVE. TOWSON, MD</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Alcoholism</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Chronic Cirrhosis, Fatty Liver, R/O Tumor, Hepatic Com.</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>type II</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>7/16</i> 19 <i>67</i> to <i>7/16</i> 19 <i>67</i> , that (we) last saw the deceased alive on <i>7/16</i> 19 <i>67</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Murray A. Katz</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/16/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>MURRAY A. KATZ</i>		23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>July 19 1967</i>		24C. NAME OF CEMETERY or CREMATORY <i>Pleasant Rest Cem.</i>	
24D. LOCATION <i>Towson, Md. Balto. County</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JUL 18 1967</i>		24F. NAME OF REGISTRAR <i>Robert E. Jackson</i>	
24G. FUNERAL DIRECTOR <i>Lewis T. Gwynn</i>		24H. ADDRESS <i>2707 Ruscombe Lane Balto. Md. 21215</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6821	
BIRTH NO. 67 6821		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JONES OTIS L.		2. DATE AND HOUR OF DEATH 7-13-1967 8.25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore, Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland		C. CITY OR TOWN (If outside city limits write RURAL and give township) Baltimore, Maryland			
		D. STREET ADDRESS (If rural, give location) 2515 Harlen Avenue 16-05			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 1, 1902	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Joseph Jones		14. MOTHER'S MAIDEN NAME Jessie Garrett	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-3468-A		17. INFORMANT ADDRESS Mrs. Carrie Jones, 2515 Harlen Ave,	
18. 434.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Congestive Heart Failure		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) ✓		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ✓		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ✓	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ✓		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ✓	
22. I certify that (I) (this hospital) attended the deceased from 7-9-1967 to 7-13-1967 , that (I) (we) last saw the deceased alive on 7-13-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nguyen Thi Oanh		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-13-67	
23C. PHYSICIAN'S NAME (Type) NGUYEN THI OANH M.D.		23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-17-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Feltz, M.D.		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave.	

John A. Doe
 Baltimore, Maryland

John A. Doe

John A. Doe, 1820

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6822	
BIRTH NO. 67 6822		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Walter M. S. Ryan		2. DATE AND HOUR OF DEATH & TIME 7/15/67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4919 Gilray Dr.		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-03 D. STREET ADDRESS (If rural, give location) 4919 Gilray Drive			
5. SEX M	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 4/25/25	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instructor		10B. KIND OF BUSINESS OR INDUSTRY Morgan State College		11. BIRTHPLACE (State or foreign country) New Castle, Delaware	
13. FATHER'S NAME Moses Ryan		14. MOTHER'S MAIDEN NAME Jeanette Bungy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 221-14-6186		17. INFORMANT ADDRESS Rebecca Rudd, 15 Holcomb La. New castle, Del.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia		CAUSE OF DEATH (A) DUE TO Cancer of Rectum		INTERVAL BETWEEN ONSET AND DEATH May 1966	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the undersigned) attended the deceased from May 1966 to July 15, 1967 , that (I) (we) last saw the deceased alive on July 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome Gaber				23B. DATE SIGNED 7/15/67	
23C. PHYSICIAN'S NAME (Type) Jerome Gaber		23D. ADDRESS 5706 Bellona Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/18/67		24C. NAME of CEMETERY or CREMATORY Mt. Salem	
24D. LOCATION (City, town, or county) (State) New Castle, Delaware		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967			
25B. NAME OF REGISTRAR Edw. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Edward Bell, Wilmington, Delaware			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 67 6823	
BIRTH NO. 67 6823		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Joseph Hill		2. DATE AND HOUR OF DEATH July 12, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2033 David H. Hill Ave			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-17-1899	9. AGE (In years last birthday) 68	10. If Under 1 Yr. Months: Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY Races		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Hill			
14. MOTHER'S MAIDEN NAME Bessie Adams		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 218-14-8521		17. INFORMANT ADDRESS Ruth Hill, 2033 Druid Hill Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 155.1 I CAUSE OF DEATH Carcinoma of gallbladder with metastasis		INTERVAL BETWEEN ONSET AND DEATH ?			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Arteriosclerotic Heart Disease					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7/11/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of gallbladder		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 28 1967 to July 12 1967 , that (I) (we) last saw the deceased alive on July 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard Harris, Jr.				23B. DATE SIGNED July 13, 1967	
23C. PHYSICIAN'S NAME (Type) Bernard Harris, Jr.				23D. ADDRESS 1200 McCulloch Street Baltimore, Md. 21217	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-67		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. JUL 18 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave.			

July 12, 1883

Dear Sir

My dear Sir

I have the honor

to acknowledge the receipt

of

your letter of the 10th

inst. in relation to the

U.S.A.

of the 10th inst.

and in reply to inform you

that the same has been

sent to the

proper authorities for their consideration.

Very

Respectfully

Yours very truly

Wm. H. H.

Chief

Enclosed for the U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

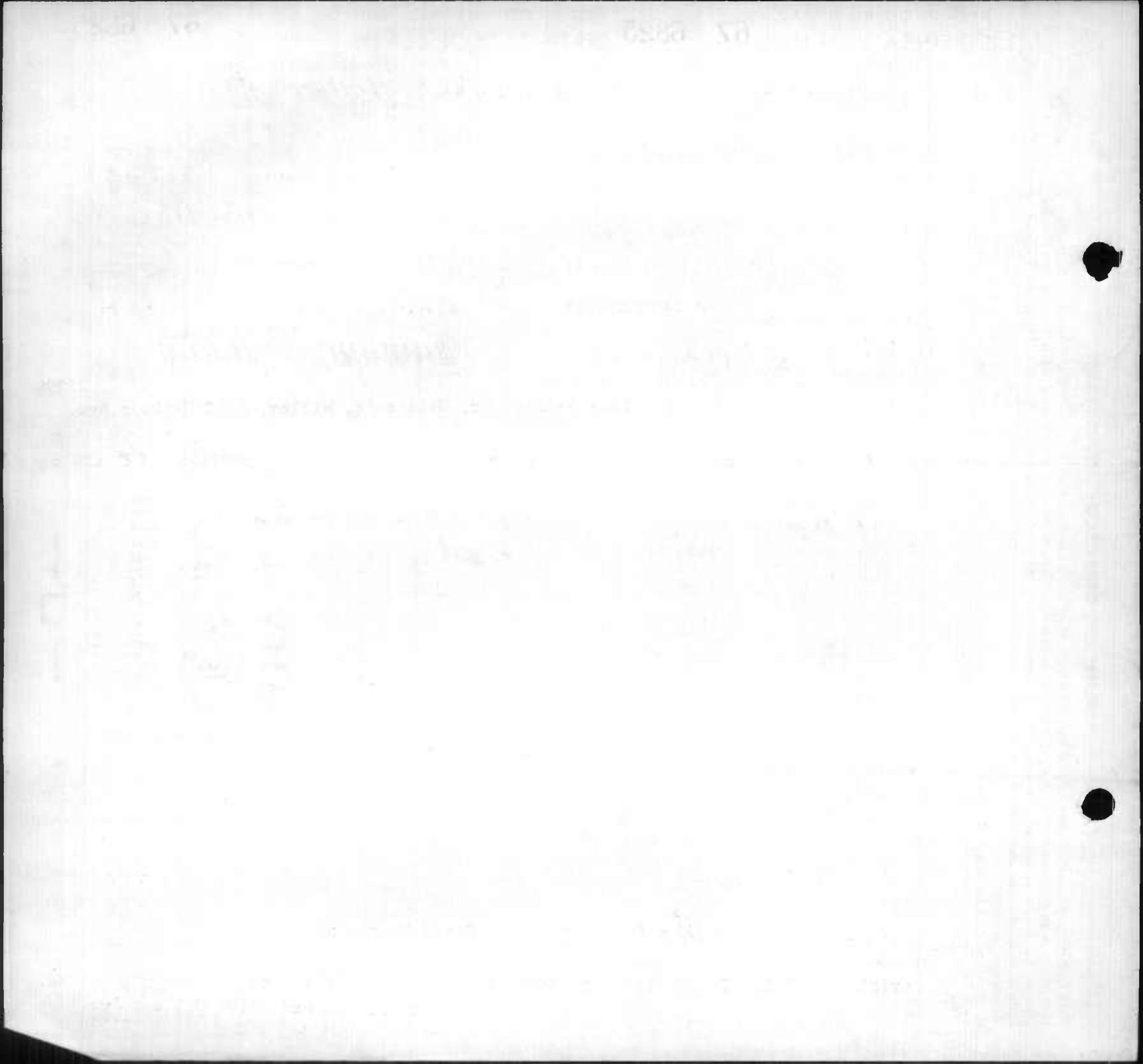
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6824
BIRTH NO. 67 6824		CERTIFICATE OF DEATH		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH July 14th, 1967 12:20 P. M.		
1. NAME OF DECEASED (Type or Print) John Middlecoff,				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co		
FULL NAME OF HOSPITAL OR INSTITUTION 40 Saint Agnes Hospital Caton & Wilkens Aves 21229		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Rosemont 53-00		
		D. STREET ADDRESS (If rural, give location) 2816 Louisiana Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/27/97	9. AGE (In years lost birthday) 17/1 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Middlecoff		14. MOTHER'S MAIDEN NAME Elizabeth Helwig		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give date) WWI US Naval Reserve 2/26/18-9/5/19		16. SOCIAL SECURITY NO. 214-03-4384		17. INFORMANT ADDRESS Mrs. Rose Middlecoff, 2816 Louisiana Ave.
18. 422.1 I Force DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH undetermined months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from May 1961 to July 12 1967 , that (I) (we) last saw the deceased alive on July 12 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Henry Armanas		23B. DATE SIGNED July 14, 1967		
23C. PHYSICIAN'S NAME (Type) HENRY ARMANAS		23D. ADDRESS 1934 Wilkens Ave. fault 23, Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-18-67	24C. NAME of CEMETERY or CREMATORY Meadowridge Mem. Park Cem.		24D. LOCATION (City, town, or county) (State) Howard Coutny, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229

[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

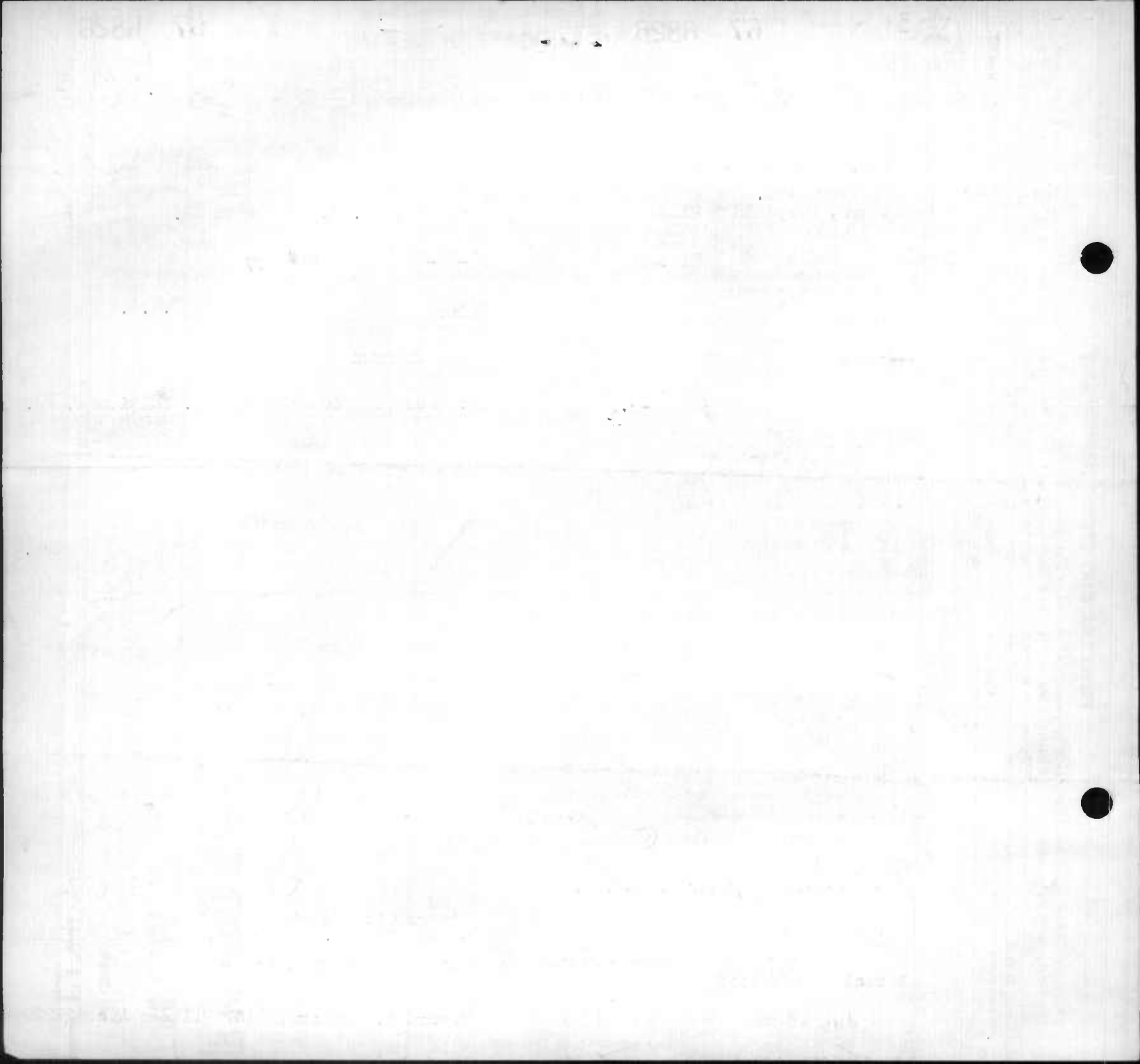
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6825	
BIRTH NO. 67 6825		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) MILLER Mrs MARY E		2. DATE AND HOUR OF DEATH 7/17/67 10 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 3412 WILKENS AVE.			
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/18/14	9. AGE (In years last birthday) 53	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY Hairdresser		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
13. FATHER'S NAME AUGUST M SPEALMAN		12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-14-4560		17. INFORMANT Mr. William S. Miller, 3412 Wilkens Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Metastatic Malignancy, rectum 18 mo.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial disease E A-V block.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---	
22. I certify that (I) (this hospital) attended the deceased from 7-6-67 19 to 7-17-67 1967, that (I) (we) last saw the deceased alive on 7-16-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Mohamadi				23B. DATE SIGNED 7-17-67	
23C. PHYSICIAN'S NAME (Type) MAHMOOD MOHAMADI		23D. ADDRESS Staff Physician			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/20/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Howard H. Hubbard	
				ADDRESS 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-362		67 6826		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6826	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>MAR Garet D. PATTERSON</u>				2. DATE AND HOUR OF DEATH <u>7-13-67</u> <u>1:10⁴⁵</u> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Maryland # 21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel Co.</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Darlington</u> <u>21034</u> <u>02562-00</u>			
				D. STREET ADDRESS (If rural, give location) <u>Box 20, Rt. 2, Castleton Rd.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-12-89</u>	9. AGE (In years lost birthday) <u>77</u>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH: Records 4940 Eastern Ave. Baltimore, Md.</u>		
18. <u>4221</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIOVASCULAR collapse</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Myocardial Infarction</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>7-5</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>			
21D. TIME OF INJURY (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>			
22. I certify that (1) (this hospital) attended the deceased from <u>5 AM 7-13-67</u> to <u>10⁴⁵ PM 7-13-67</u> , that (1) (we) last saw the deceased alive on <u>7-13-67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Patrick Desmond</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-13-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Patrick Desmond</u>				23D. ADDRESS M.D. <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Maryland # 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/18/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Elsworth Town Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Elsworth, Maine</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 18 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, MA</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 6827		67 6827	
CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		ROBERT E. HEALY		2. DATE AND HOUR OF DEATH 7/15/67 12 ²⁸ AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE 8. COUNTY MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
42		D. STREET ADDRESS (If rural, give location) 712 CATHEDRAL ST. HOTEL ALCAZAR			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 3/10/10	9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KOGAN PRINTING CO. (Pressman)
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT PATIENT	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) Arteriosclerotic Heart Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 24 days 6 MONTHS	
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 6/19/67 19 67 to 7/15 19 67, that (I) (we) last saw the deceased alive on 7/14/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald Daitch		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/15/67	
23C. PHYSICIAN'S NAME (Type) RONALD DAITCH		23D. ADDRESS M.D. SINAI HOSPITAL OF BALTIMORE INC. BALTIMORE MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/18/67		24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	
24D. LOCATION BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967			
25B. NAME OF REGISTRAR H. W. MEARS & SON		25C. FUNERAL DIRECTOR 805 N. CALVERT S			

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U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

TO THE DIRECTOR
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

FROM THE
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

SUBJECT
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

RE: [illegible]
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

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WASHINGTON, D.C.

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WASHINGTON, D.C.

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U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6828		67 6828		67 6828	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BERTA ABT		JULY 14, 1967 4:45 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
00 5606 KEY AVE		D. STREET ADDRESS (If rural, give location) 5606 KEY AVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 10/24/1880	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME MEIR			14. MOTHER'S MAIDEN NAME PAULINE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				RICHARD MEIER - SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 330, XI		CAUSE OF DEATH (A) DUE TO Cerebral embolus		INTERVAL BETWEEN ONSET AND DEATH 2 hr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Cerebral Sclerosis - (2 strokes prior)		4 years	
		(C) DUE TO General arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Cerebral decompression, Kidney stones			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from for 15 years 19 to her death 7/14/67, that (I) (we) last saw the deceased alive on 7/9/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kurt B. Leary				23B. DATE SIGNED 7/15/67	
23C. PHYSICIAN'S NAME (Type) Kurt B. Leary				23D. ADDRESS M.D. 3105 d. Charles St. Baltimore 18 2/10	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/16/1967		24C. NAME OF CEMETERY or CREMATORY ROSEDALE	
				24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS SYLVANUS LEWIS & Son, Inc - GARRISON, MD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6829	
BIRTH NO. 67 6829		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) IDA HYMAN		2. DATE AND HOUR OF DEATH JULY 14, 1967 11 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5533 GIST AVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 1883	9. AGE (In years last birthday) 84	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) LITA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MAIER FIVEL			14. MOTHER'S MAIDEN NAME RESSIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MR. PHILIP HYMAN 6001 PARK HEIGHTS AVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 420.1 I		CAUSE OF DEATH (A) DUE TO Acute Coronary Thrombosis (B) DUE TO ASCVD (C) Chronic Malnutrition		INTERVAL BETWEEN ONSET AND DEATH 1 hr years	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/1/66 19 to 7/14/67 19, that (I) (we) last saw the deceased alive on 7/14/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Shear M.D.				23B. DATE SIGNED 7/14/1967	
23C. PHYSICIAN'S NAME (Type) JOSEPH SHEAR		23D. ADDRESS 6715 PARK HEIGHTS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/16/1967		24C. NAME OF CEMETERY or CREMATORY Brian & Sons	
24D. LOCATION (City, town, or county) (State) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, Md		25C. FUNERAL DIRECTOR ADDRESS Sylvan S. Lewis & Son, Inc. Garrison, Md			

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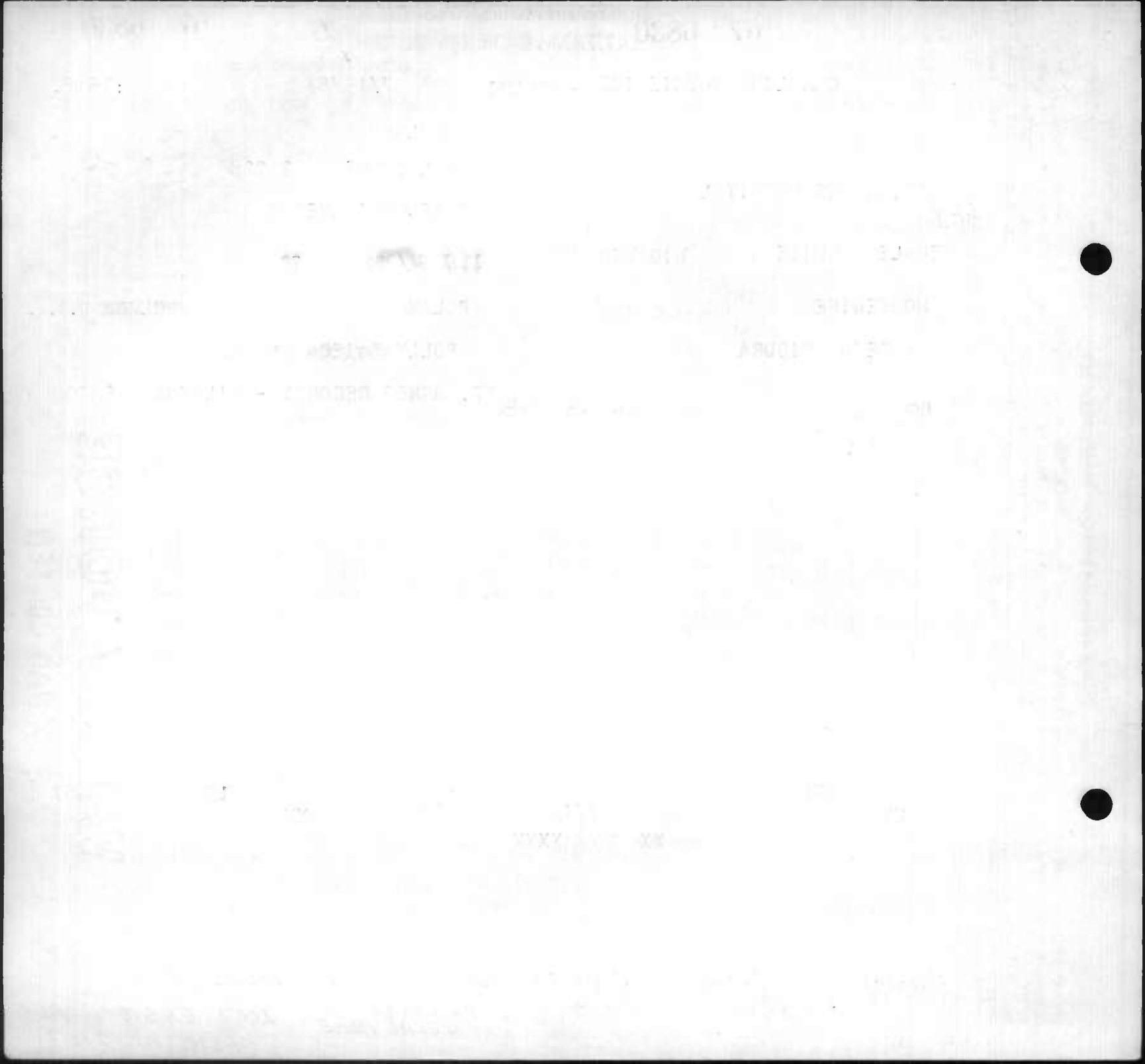
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6830		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6830	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) CAROLINE SUTKIEWICZ - SMITSKI			2. DATE AND HOUR OF DEATH 7/15/67 7:35 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL </div> <div> <small>(If not in hospital or institution, give street address or location)</small> </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE MARYLAND </div> <div> B. COUNTY Balto. C. </div> </div> <div style="display: flex; justify-content: space-between;"> <div> C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228 </div> <div> D. STREET ADDRESS (If rural, give location) 9 KENWOOD AVENUE </div> </div>		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 11 / 9 / 96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME JOSEPH MIDURA			14. MOTHER'S MAIDEN NAME POLLY ZIEMBA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-48-9918		17. INFORMANT ADDRESS ST. AGNES RECORDS - WILKENS & CATON AVE	
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <i>Myeloproliferative disease</i> (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6/17 1967 to 7/15 1967, that (X) (we) last saw the deceased alive on 7/15 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE <i>S. Korbuly</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) S. KORBULY				23D. ADDRESS <i>St. Agnes Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-19-67		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL Cem	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967			
25B. NAME OF REGISTRAR <i>ALICE J. D. H.</i>		25C. FUNERAL DIRECTOR ADDRESS FALKOWSKI FUNERAL HOME 2007 EASTERN AVE. BALTO. MD. 21231			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6831	
67 6831				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		HARRY F. JEFFRES		7-17-67 1:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL		A. STATE MD.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
34		D. STREET ADDRESS (If rural, give location) 304 S. PULASKI ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
MALE	WHITE	MARRIED	10/12/88	78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CHAUFFEUR		PARCEL DELIVERY		BALTO., MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
HARRY T. JEFFRES		ELIZABETH LITZ		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO NONE		215-07-2697		MRS. G. E. JEFFRES 304 S. Pulaski St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331 X I		(A) DUE TO		Cerebral Vascular Accident	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/14 19 67 to 7/17 19 67, that (I) (we) lost saw the deceased alive on 7/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
KYE YOON KIM M.D.				7/17	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
KYE YOON KIM M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		7-20-67		London Park	
				BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 18 1967		Robert E. Johnson		Geo. L. Schuchman Funeral Home 2101 Frederick Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6832	
BIRTH NO. 67 6832		CERTIFICATE OF DEATH		67 6832	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RAYMOND GEORGE COOPER		2. DATE AND HOUR OF DEATH 7/13/67 2 30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bow Secours Hospital		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 20-03	
D. STREET ADDRESS (If rural, give location) 421 South Payson Street		5. SEX Male		6. RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 3/11/19		9. AGE (In years, lost birthday) 49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lester I. Cooper		14. MOTHER'S MAIDEN NAME Della King	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-09-7086		17. INFORMANT ADDRESS Mrs. Evelyn Cooper-Baltimore Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11		CAUSE OF DEATH (A) DUE TO Recurrent acute myocardial infarct (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7-13-1967 to 7-13-1967 , that (I) (we) last saw the deceased alive on 7-13-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Octavio A. Ruiz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/13/67	
23C. PHYSICIAN'S NAME (Type) Octavio A. Ruiz		M.D. 23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-15-66		24C. NAME OF CEMETERY Greenwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore - Frederick Md		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Leete Funeral Home - Baltimore - Md		ADDRESS			

For James Brown

Mrs. White

April 11

412 Sumner St
Chicago

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 6833					CERTIFICATE OF DEATH				
M.E. CASE NO. 97410					Registered No. 67 6833				
1. NAME OF DECEASED (Type or Print) <u>WILLIS SMITH</u>					2. DATE AND HOUR OF DEATH <u>7-16-67 - 12:20 PM</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>DON SECOURS HOSPITAL</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <u>170 PASADENA AVE. BOX 105 LAKESHORE DR.</u>				
5. SEX <u>MALE</u>					6. RACE <u>WHITE</u>				
7. MARRIED, NEVER MARRIED <u>WIDOWED</u>					8. DATE OF BIRTH <u>6-9-'03</u>				
9. AGE (In years last birthday) <u>64</u>					10. AGE (In years last birthday) <u>64</u>				
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>WILLIS SMITH</u>					14. MOTHER'S MAIDEN NAME <u>ROSS</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>218-28-0223</u>				
17. INFORMANT <u>Mr Ross Smith</u>					ADDRESS <u>Box 105 Pasadena Md</u>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma sigmoid 1 1/2 years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>general abd. metastases 1 month</u>									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>									
21. MEDICAL CERTIFICATION 9A. DATE OF OPERATION <u>6-26-67</u>					9B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>obstruction (colon)</u>				
22. 10A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>					22. 10B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u>				
23. 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>March 3 1966 to July 16 1967</u>					23. 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
24. 21F. HOW DID INJURY OCCUR? <u>March 3 1966 to July 16 1967</u>					24. 21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>July 16 1967</u>				
25. 23A. SIGNATURE <u>J. Sullivan</u>					25. 23B. DATE SIGNED <u>7-16-67</u>				
26. 23C. PHYSICIAN'S NAME (Type) <u>J. Sullivan</u>					26. 23D. ADDRESS <u>1129 St Paul St. Baltimore 2 Md</u>				
27. 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					27. 24B. DATE <u>7/20/67</u>				
28. 24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill</u>					28. 24D. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. A.A. Co. Md.</u>				
29. 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 18 1967</u>					29. 25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>				
30. 25C. FUNERAL DIRECTOR <u>McCall's Funeral Home</u>					30. 25D. ADDRESS <u>237 Patuxent Ave</u>				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6834		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6834	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Perez Mr Harry			2. DATE AND HOUR OF DEATH 7-14-67 12⁰⁵ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital 34			A. STATE Maryland B. COUNTY Baltimore		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1007 S. Potomac St.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-3-15	9. AGE (In years last birthday) 51	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Eng. Key Highway Bethlehem Steel Co.			11. BIRTHPLACE (State or foreign country) Puerto Rico		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Jose Perez			14. MOTHER'S MAIDEN NAME Beranza Murgas		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 090-05-5014		17. INFORMANT (Name) Mrs. Christine Perez, 1007 S. Potomac St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) VENTRICULAR FIBRILLATION			CAUSE OF DEATH (A) DUE TO MYOCARDIAL ISCHEMIA		INTERVAL BETWEEN ONSET AND DEATH 1/2 HR
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SUBACUTE BACTERIAL ENDOCARDITIS			(B) DUE TO AORTIC INSUFFICIENCY		2 MONTHS
(C) CONGESTIVE FAILURE					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-14-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-9-67 to 7-14-67 , that (I) (we) lost saw the deceased alive on 7-14-67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aidan E. Walsh				23B. DATE SIGNED 7-14-67	
23C. PHYSICIAN'S NAME (Type) AIDAN E. WALSH				23D. ADDRESS 715 N. CHARLES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/18/67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D. BY HEALTH DEPT. JUL 18 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR John J. Duda, 2829 Hudson St. Balto. Md.			

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VENTILATOR
PNEUMATIC
SUGAR FACTORY
BUTTER
CORRECTIVE FAILURE

500 1120

22 JAN 19 1971

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 32-36350	
BIRTH NO. 67 6835		CERTIFICATE OF DEATH		32-36350	
M.E. CASE NO. 32-31-50		1. NAME OF DECEASED (Type or Print) Frank Baranoski		2. DATE AND HOUR OF DEATH 7/16/67 1 1 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
1 BALTIMORE CITY HOSPITALS		D. STREET ADDRESS (If rural, give location)		802 South Lakewood Avenue 21224	
4940 Eastern Avenue, Baltimore, Maryland		5. SEX Male		6. RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 11-3-97		9. AGE (In years lost birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Shipyard		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Baranoski		14. MOTHER'S MAIDEN NAME Mary Holewinski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-2402		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) PNEUMONIA SEPTICEMIA		5 DAYS	
ANTECEDENT CAUSES		(B) PNEUMONIA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) AMPUTATION LEFT LEG.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DEMENTIA - ARTERIO SCLEROSIS			
19A. DATE OF OPERATION 6-22-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ARTERIO SCLEROSIS		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-30-1962 to 7/16/1967, that (I) (we) last saw the deceased alive on 7/16/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Enrique Castro		23B. DATE SIGNED 7/16/67	
23C. PHYSICIAN'S NAME (Type) ENRIQUE CASTRO		23D. ADDRESS BALTIMORE CITY HOSPITALS GENERAL SURGICAL DEPT			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/20/67		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Fabela	
25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 2829 Hudson St. Balto. Md.			

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67 6836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 6836

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Josephine Sakowski (Gravels)

DATE AND HOUR OF DEATH

July 16, 1967 12⁴⁵ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland Baltimore Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore - Dundalk

D. STREET ADDRESS (If rural, give location)

4068 Beach Rd.

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

2-21-00

9. AGE (In years
lost birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Lisiecki

14. MOTHER'S MAIDEN NAME

Mary Batory

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

RECORDS: BCH 4940 EASTERN AVE. BALTO.

ADDRESS
21224, MD.

18. 260 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Myocardial Infarction 6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

Arteriosclerotic Vas. Disease 10 yrs.

(C) DUE TO

Diabetes 10 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pneumonia, CVA

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 10 1967 to July 16 1967,
that (I) (we) last saw the deceased alive on July 16 1967 and that in my (our) opinion death occurred on the date
and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

E. M. Levinsohn

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

July 16, 1967

23C. PHYSICIAN'S
NAME (Type)

DR. E. M. LEVINSOHN

M.D.

23D. ADDRESS

AVENUE BALTIMORE 21224, MD.

BALTIMORE CITY HOSPITALS 4940 EASTERN

24A. BURIAL CREMATION, DATE
REMOVAL (Specify)

Burial

7/20/67

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart of Mary Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 18 1967

25B. NAME OF REGISTRAR

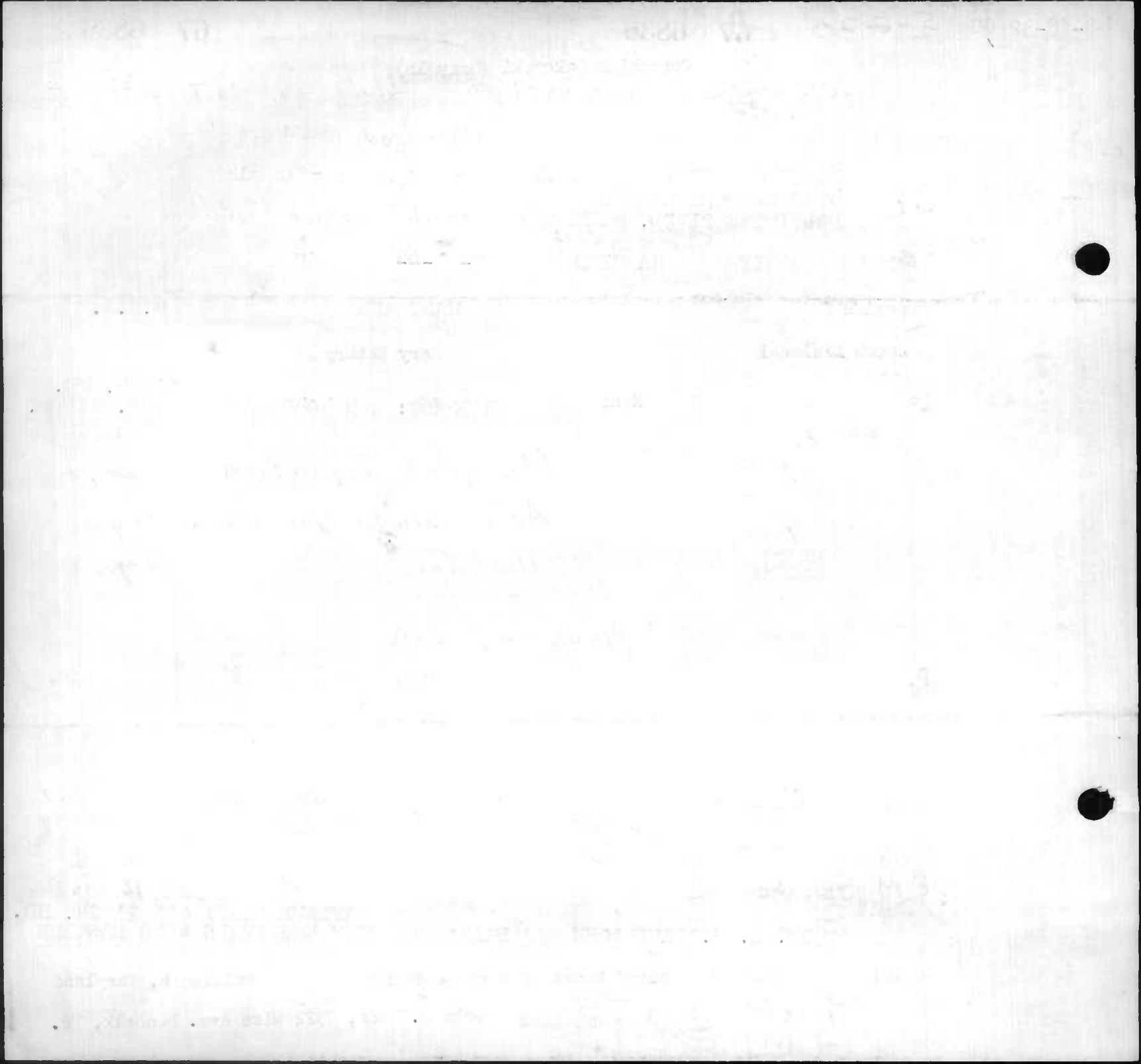
Robert E. Fairbank

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LAWRENCE

NORMAN / THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

July 16, 1967 7:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CITY HOSPITAL D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Wicomico Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

B. Salisbury

D. STREET ADDRESS (If rural, give location)

309 E. College Avenue Salisbury

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Divorced

8. DATE OF BIRTH

August 18, 1928

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Equipment Operator

10B. KIND OF BUSINESS OR INDUSTRY

Road Construction

11. BIRTHPLACE (State or foreign country)

Denton, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Henry Thomas

14. MOTHER'S MAIDEN NAME

Mary Elizabeth Slaughter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1950-1954

16. SOCIAL
SECURITY NO.

218-20-8543

17. INFORMANT

Mr. Charles H. Thomas, Jr., (Brother)

309 E. College Avenue, Salisbury, Maryland

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular
Disease

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 19, 1967

23C. NAME OF CEMETERY OR CREMATORY

Wicomico Memorial Park

23D. LOCATION

Salisbury, Maryland

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

HOLLOWAY & COMPANY, SALISBURY, MARYLAND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6838		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6838	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRANCES ANNA BITTMAN		2. DATE AND HOUR OF DEATH July 13, 1967 5.30 p M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 21205 B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 7-03			
		D. STREET ADDRESS (If rural, give location) 942 N. Collington Ave.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10/26/86	9. AGE (In years last birthday) 80	10. Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Anton Skirvan		14. MOTHER'S MAIDEN NAME Frances Vodak			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Edward Bittman, son, 2116 E. Madison St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 422.141 904.9 (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) malnutrition, congestive heart failure		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH several weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		A.S.C.V.D.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		fracture right hip		4 weeks	
19A. DATE OF OPERATION June 15 '67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fractured right hip		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes.	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ?	
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 30k 1967 to July 13 1967, that (I) (we) last saw the deceased alive on 7-13-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-14-67	
23C. PHYSICIAN'S NAME (Type) Dr. Ellsworth Cook		23D. ADDRESS 2431 Maryland Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/17/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.	

W. B. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6839		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6839	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) FREDERICKS, IDA C			2. DATE AND HOUR OF DEATH JULY 13, 1967 10:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21043 C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLCOTT CITY D. STREET ADDRESS (If rural, give location) 195 MAIN ST.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9/28/01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM (LAST NAME UNKNOWN)			14. MOTHER'S MAIDEN NAME ANNA (DYER) LAST NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216 28 3050		17. INFORMANT ADDRESS HOSPITAL RECORDS- ST. AGNES HOSPITAL	
18. 175.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cystadenocarcinoma of ovary ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH > 6 mos.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 13, 1967 to JULY 13, 1967 , and that (X) (we) last saw the deceased alive on JULY 13, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>George E. Engleeke</i> M.D.				23B. DATE SIGNED 7/13/67	
23C. PHYSICIAN'S NAME (Type) GEORGE E. ENGLEEKE			23D. ADDRESS AVES., BALTO., MD. 21229 ST. AGNES HOSPITAL- CATON AND WILKENS		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-18-67		24C. NAME OF CEMETERY or CREMATORY Good Shepherd	
24D. LOCATION (City, town, or county) (State) Ellicott City, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Higginbotham - Slack</i> Funeral Home			
25D. ADDRESS Ellicott City Md.					

WASHINGTON, D.C.

JULY 13, 1963

10:15

ST. AGNES HOSPITAL

ELIZABETH CITY

100 MAIN ST.

012640 22

WIDOWED WHITE FEMALE

USA WASHINGTON

HOUSEWIFE

ANNA (DYER) LAST NAME UNKNOWN

WILLIAM (LAST NAME UNKNOWN)

210 25 3050 HOSPITAL RECORDS - ST. AGNES HOSPITAL

NO

27 JULY 63

WHITE IS

JULY 13,

XX

X

ST. AGNES HOSPITAL - CATHY A.D. WILLIAMS
AVENUE, BALTO., MD. 21203

GEORGE E. EISENBERG

Handwritten notes and stamps at the bottom of the page.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6840

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 6840

BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		MARGARET M. CHAMBERS		7-15-67 12.30 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
33 THE JOHNS HOPKINS HOSPITAL		MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		808 N LUZERNE AVE 21205			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	WIDOWED	1-24-86	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		at home		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN KROPFELDER			MARGARET		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
215-05-8848D				Mary Trojanowski, neice, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
570.21 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Mantene vein thrombosis + infected intestine		2 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
7/13/67		INFARCTION OF BOWEL		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12 July 1967 to 15 July 1967, that (I) (we) lost saw the deceased alive on 15 July 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A. G. Ravilla Jr. M.D.				7-15-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
A.G. RAVILLA, JR.		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	7/18/67	Holy Redeemer Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 18 1967		Robert E. Farley, Jr.		Schimunek Funeral Home, Inc. 2601 E. Madison St.	

Handwritten text, possibly a signature or name, oriented vertically.

Handwritten text, possibly a signature or name, oriented horizontally.

9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6841 CERTIFICATE OF DEATH					Registered No. 67 6841				
1. NAME OF DECEASED (Type or Print) CLIFTON JOHN BELTZ					2. DATE AND HOUR OF DEATH July 15, 1967 4⁰⁰ P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House in the Pines (Belair Rd)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-10 D. STREET ADDRESS (If rural, give location) 505 N. Clinton St.				
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify) married	8. DATE OF BIRTH 6/21/98	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Amer. Smelting & Refining Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME George Beltz			14. MOTHER'S MAIDEN NAME Elizabeth Burkemeyer						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 212-10-1325			16. SOCIAL SECURITY NO. 212-10-1325		17. INFORMANT ADDRESS Lillian Hopkins Beltz, wife, above				
18. 334 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthemio, etc. It means the disease, injury or complication which caused death.) Multiple Strokes ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Granulosis Arteriosclerosis					CAUSE OF DEATH (A) Multiple Strokes DUE TO (B) Granulosis Arteriosclerosis DUE TO (C) _____				
INTERVAL BETWEEN ONSET AND DEATH 4 days.									
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Parkinson's Disease									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (was did) attended the deceased from 6/27/67 to 7/15/67 that (I) (we) last saw the deceased alive on 7/14/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was did) (did not) view the body after death.									
23A. SIGNATURE Albert B Bradley					M.D. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/17/67		
23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley					23D. ADDRESS 4900 Belair Road				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/18/67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane			

1890

Multiple other
cases occurred

Persons. Name

State of
Ohio

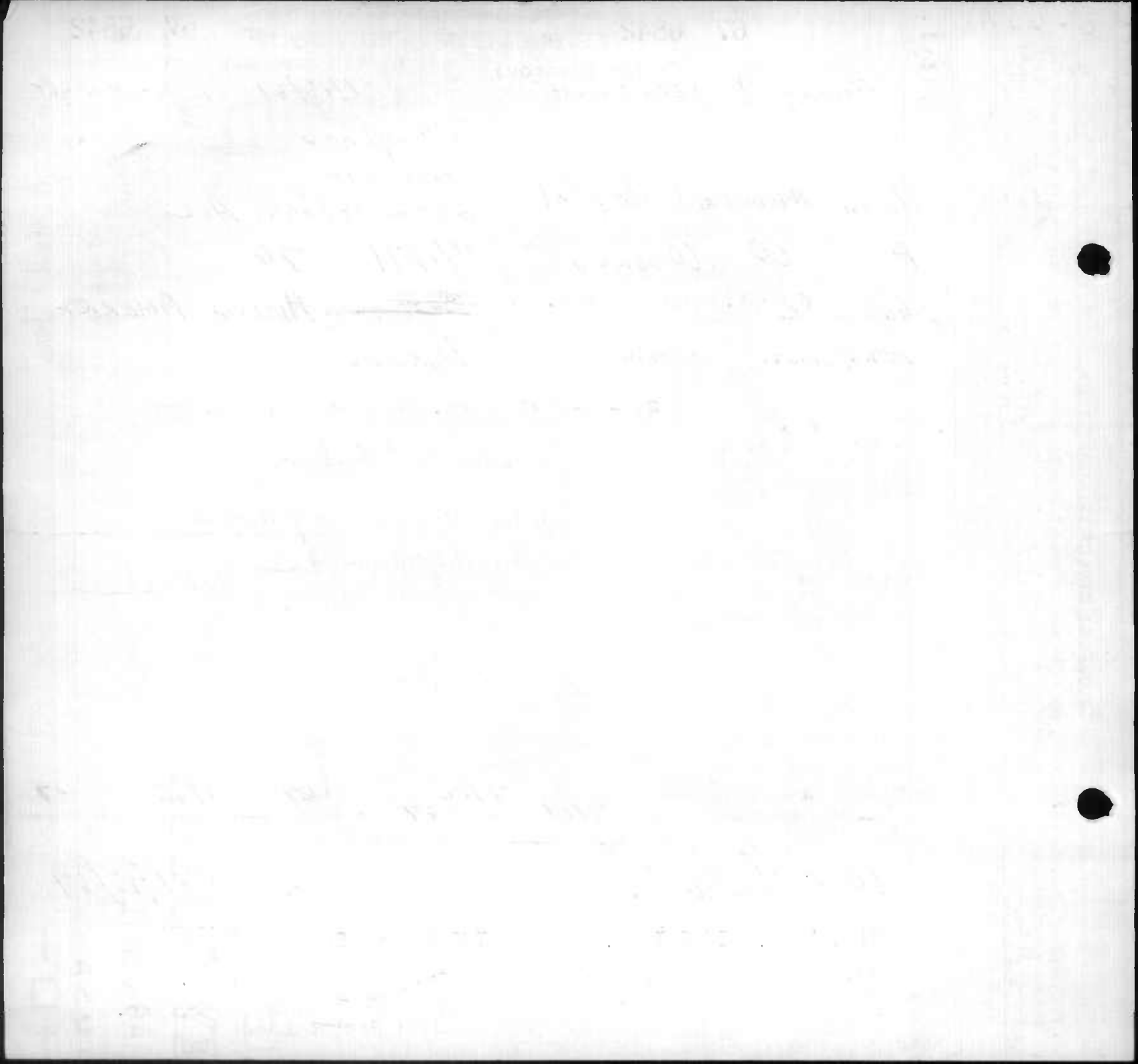
State of
Ohio

See a copy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6842		67 6842		67 6842	
CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Milka (or Berarov) MARY M. PERKOVICH			2. DATE AND HOUR OF DEATH 7/15/67 12 MIDNIGHT M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21-01 D. STREET ADDRESS (If rural, give location) 2882 Pelham Ave		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 4/1/91	9. AGE (In years last birthday) 76	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaford Dept. Housewife			10B. KIND OF BUSINESS OR INDUSTRY Miller Bros.		11. BIRTHPLACE (State or foreign country) AUSTRIA
12. CITIZEN OF WHAT COUNTRY? AMERICA			13. FATHER'S NAME Miucsin		
14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 215-14-5197			17. INFORMANT Mrs. Mary Loesch, dght, above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Corpective heart failure			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic coronary disease			20. (C) bronchopneumonia		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/12 19 67 to 7/15 19 67 , that (I) (we) last saw the deceased alive on 7/14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. H. Oehlert Jr.				23B. DATE SIGNED 7/15/67	
23C. PHYSICIAN'S NAME (Type) WILLIAM H. OEHLERT JR.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/18/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967			
25B. NAME OF REGISTRAR Paul E. Farley, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.			
25D. ADDRESS 3331 Brehms Lane					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 67 6843	
BIRTH NO. 67 6843					
M.E. CASE NO. A.					
1. NAME OF DECEASED (Type or Print) THERESA HASKE		2. DATE AND HOUR OF DEATH JULY 16, 1967 1:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-01 D. STREET ADDRESS (If rural, give location) 1509 LESLIE ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/15/96	9. AGE (In years last birthday) 71 years	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10B. KIND OF BUSINESS OR INDUSTRY Balto. County		11. BIRTHPLACE (State or foreign country) Baltimore MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICA		13. FATHER'S NAME LUDWIG GRILL			
14. MOTHER'S MAIDEN NAME THERESA GRILL Fuchs		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 217-12-5109			
16. SOCIAL SECURITY NO. 217-12-5109		17. INFORMANT ADDRESS Anthony F. Haske, husband, above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.01 MYOCARDIAL INSUFFICIENCY		CAUSE OF DEATH (A) MYOCARDIAL INSUFFICIENCY DUE TO (B) ARTERIOSCLEROTIC HEART DISEASE DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH week years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 15, 1967 to July 16, 1967 , that (I) (we) last saw the deceased alive on July 16, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim Banzaga M.D.		23B. DATE SIGNED July 16, 1967		23C. PHYSICIAN'S NAME (Type) Ephraim Banzaga M.D.	
23D. ADDRESS CHURCH HOME AND HOSPITAL					
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/20/67		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	

John B. B. B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-13535</u> <u>67</u> <u>6844</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. <u>67</u> <u>6844</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MILLER, BABY BOY</u>		2. DATE AND HOUR OF DEATH <u>7/13/67</u> <u>345</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI Hosp. OF BALTIMORE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>5709 SIMMONDS AVE.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>7/12/67</u>	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days <u>21</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND, Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MILLER, MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>PAQUET, MARY ANN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT ADDRESS <u>Mr. Martin Miller, 5709 Simmonds Avenue</u>	
18. <u>77351</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY DISTRESS</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 HRS</u>		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>PREMATURITY</u>			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>7/12/67</u> to <u>7/13/67</u> , that (I) (we) last saw the deceased alive on <u>7/13/67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Thomas P. Smith</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7/13/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Thomas P. Smith</u>		M.D. <u>SINAI Hosp. OF BALTIMORE</u>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/14/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>BETH JACOB</u>	
24D. LOCATION (City, town, or county) (State) <u>FINKSBURG, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 18 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fink</u>	
25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u>					

The first of these is the
 fact that the population of
 the country is increasing
 rapidly. This is due to
 the fact that the country
 is fertile and the people
 are industrious.

The second of these is the
 fact that the country is
 rich in natural resources.
 This is due to the fact
 that the country is large
 and the people are
 industrious.

The third of these is the
 fact that the country is
 rich in minerals. This
 is due to the fact that
 the country is large and
 the people are industrious.

67 6845

BALTIMORE CITY HEALTH DEPARTMENT

67 6845

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELEANOR FLEISCHMANN

2. DATE AND HOUR PRONOUNCED DEAD

July 12, 1967 12:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Park Towers Apartments
7121 Park Heights Avenue4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Pennsylvania

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Marion

D. STREET ADDRESS (If rural, give location)

Latches Lane Apts.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

July 3, 1887

9. AGE (In years
last birthday)

80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Philadelphia, Pa.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank S. Fleischmann

14. MOTHER'S MAIDEN NAME

Victoria Pansci

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

Unknown

17. INFORMANT

Oliver H. Baer Funeral Home, 1820 Chestnut St.

ADDRESS

Phila., Pa.

18.

420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) with recent myocardial infarction
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☒ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial-Removal 7/14/67

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

Fernwood Cemetery

23D. LOCATION

(City, town, or county)

Delaware County, Pa.

(State)

24A. DATE RECEIVED BY HEALTH DEPT.

JUL 18 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Sol Levinson & Bros. Inc., 610 Reist., Rd.

ADDRESS



WILEY HODGE

WILEY HODGE

WILEY HODGE

WILEY HODGE

WILEY HODGE

WILEY HODGE

WILEY HODGE

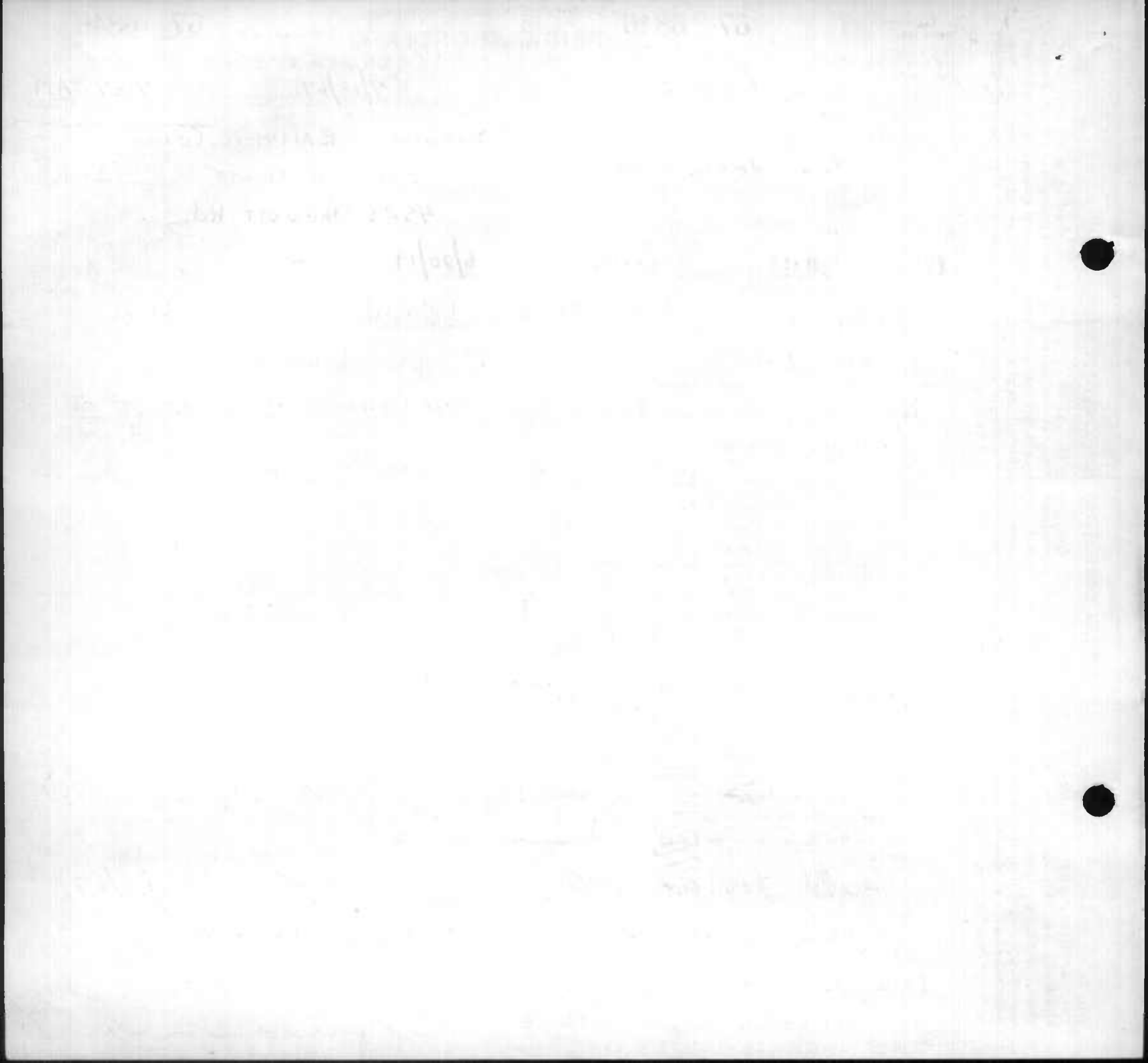
WILEY HODGE

WILEY HODGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

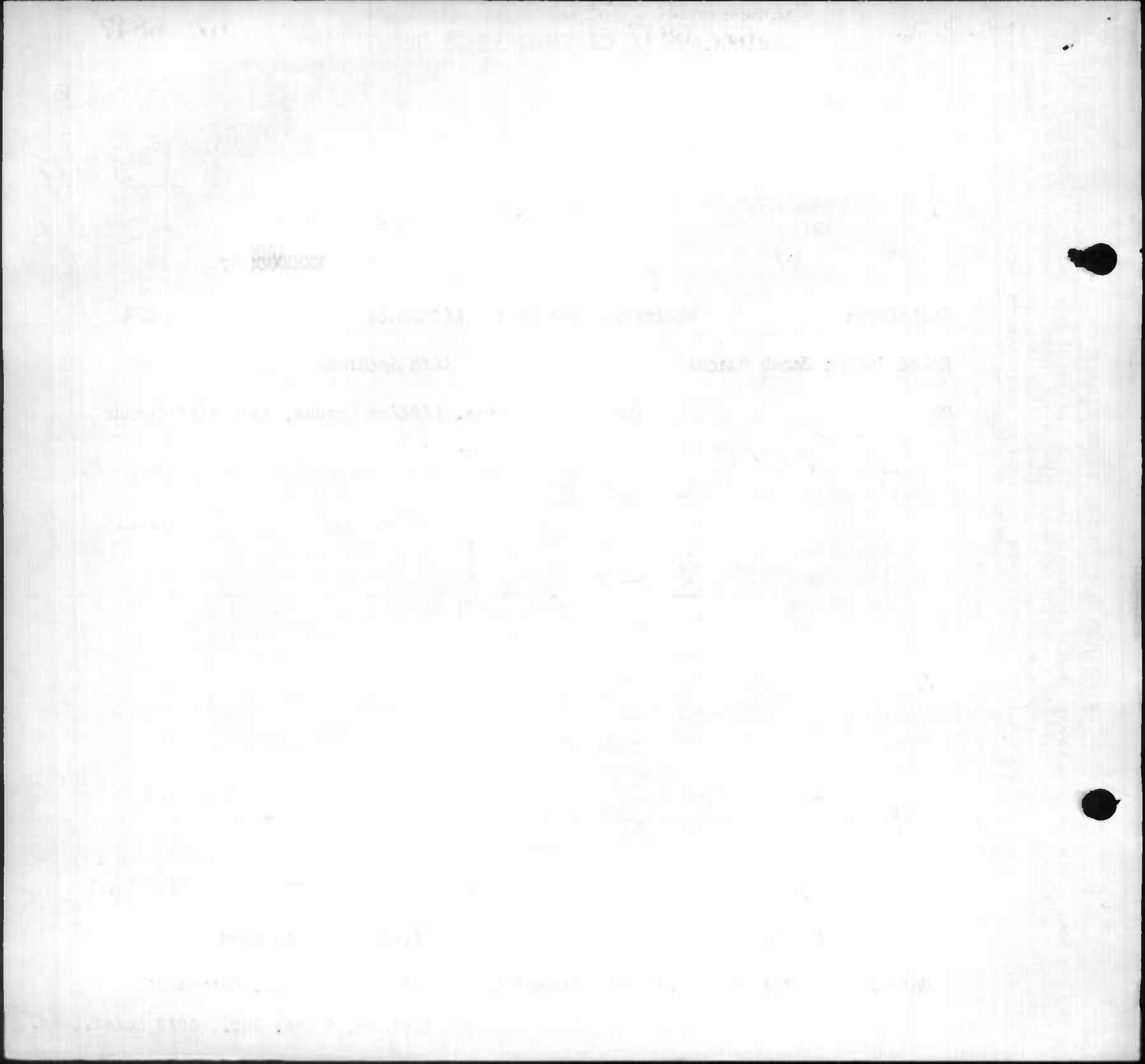
BIRTH NO. 67 6846		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6846	
1. NAME OF DECEASED (Type or Print) Solomon EICHNER			2. DATE AND HOUR OF DEATH 7/13/67 7:37 AM.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL OF BALTIMORE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE COUNTY 53-00 D. STREET ADDRESS (If rural, give location) 4528 TAPSCOTT Rd.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/20/19	9. AGE (In years last birthday) 48	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing Supervisor		10B. KIND OF BUSINESS OR INDUSTRY RAG PACKING		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME ISRAEL EICHNER			14. MOTHER'S MAIDEN NAME MIRIAM WALMER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 287-28-9402		17. INFORMANT ADDRESS GALL EICHNER 4528 TAPSCOTT Rd	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE			CAUSE OF DEATH (A) BRONCHIOGENIC CARCINOMA DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 05/31/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRONCHIOGENIC CARCINOMA		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3 1967 to July 13 1967 , that (I) (we) last saw the deceased alive on July 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald Schachar MD				23B. DATE SIGNED 7/13/67	
23C. PHYSICIAN'S NAME (Type) RONALD SCHACHAR				23D. ADDRESS M.D. SINAI HOSPITAL OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-67		24C. NAME OF CEMETERY or CREMATORY Shaarei Zedek	
24D. LOCATION BALTO., Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sal Liscian Bros Inc.	
				ADDRESS 6010 Rust	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6847	
BIRTH NO. 22		67 6847		CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Gilbert Marcus			7/13/67 1415 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 Levindale - Hebrew Home and Infirmary			A. STATE Maryland B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 5535 Gist Ave		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 12-15-09	9. AGE (In years lost birth date) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10B. KIND OF BUSINESS OR INDUSTRY Wholesale Mens Wear		11. BIRTHPLACE (State or foreign country) Lithuania	
13. FATHER'S NAME Rabbi Joseph Jacob Marcus		14. MOTHER'S MAIDEN NAME Alta Spintman		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-01-6312		17. INFORMANT Mrs. Lillian Marcus, 5535 Gist Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I			CAUSE OF DEATH (A) Cerebral vascular accident (B) generalized ASCVD (C)		INTERVAL BETWEEN ONSET AND DEATH 2 years years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 1-4-66 19 to 7/13/67 19, that (he) (we) last saw the deceased alive on 7/13/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Susan Logat				23B. DATE SIGNED 7/13/67	
23C. PHYSICIAN'S NAME (Type) Susan Logat				23D. ADDRESS Levindale Aged Home	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/67		24C. NAME OF CEMETERY OR CREMATORY Tifereth Israel Anshe Sfard	
24D. LOCATION Rosedale, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25A. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25B. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.		25C. ADDRESS			



N-352

67 6848		BALTIMORE CITY HEALTH DEPARTMENT		67 6848	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) ALBERT J. NATHANSON			2. DATE AND HOUR PRONOUNCED DEAD July 14, 1967 4:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL (DOA)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3017 Garrison Blvd.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 77	9. AGE (In years last birthday) 77 If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME ABBA NATHANSON			14. MOTHER'S MAIDEN NAME ANNA ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) WW 1 ARMY		16. SOCIAL SECURITY NO. 219-38-0566	17. INFORMANT ADDRESS MRS NORMA POSNER CAVES ROAD BALTIMORE, MD.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E816.4 Multiple Injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Southwest Blvd. & Knecht Avenue	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (P. M.) 7 14 '67 4:13 P. M.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Subj. failed to yield right of way - was hit on left side - lost control of car and hit telephone pole	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. DATE SIGNED 7/15/67 EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 7/16/67		23C. NAME OF CEMETERY or CREMATORY BETH TFILOH	
24A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS 6010 REISTERSTOWN RD.	

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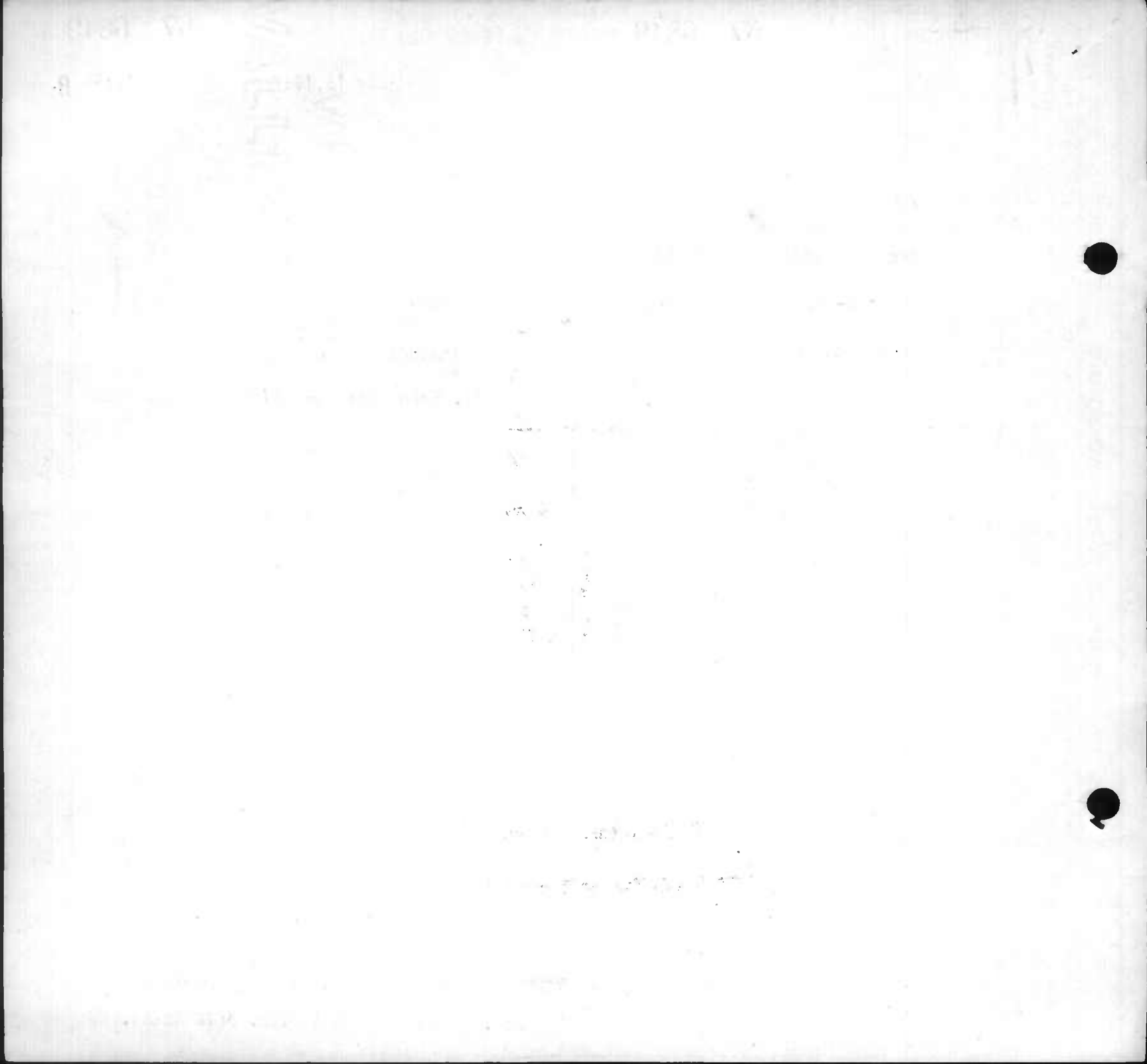
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6849 CERTIFICATE OF DEATH					Registered No. 67 6849				
BIRTH NO. 155									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
TODRYS RACHMAN					July 15, 1967 11:55 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital					A. STATE Maryland				
(If not in hospital or institution, give street address or location)					B. COUNTY Baltimore Co				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					Baltimore				
D. STREET ADDRESS (If rural, give location)					6513 Wickfield Road				
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH		9. AGE (In years last birthday) 67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk		10B. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? ? U.S.A.			
13. FATHER'S NAME Dov Rachman					14. MOTHER'S MAIDEN NAME Brandle ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. [REDACTED]				
17. INFORMANT Mrs. Toba Burstyn- 6513 Wickfield Road					ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH Acute myocardial infarction Deterioration of cardiovascular system disease				
INTERVAL BETWEEN ONSET AND DEATH Several years									
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 19 66 to July 15 19 67, that (I) (we) last saw the deceased alive on March 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.									
23A. SIGNATURE [Signature]					23B. DATE SIGNED 7/16/67				
23C. PHYSICIAN'S NAME (Type) Seymour H. Rubinstein					23D. ADDRESS 5415 Park Heights Ave.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE July 16/67				
24C. NAME OF CEMETERY or CREMATORY Lubowitz Nusi Ari					24D. LOCATION (City, town, or county) (State) Rosedale, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967					25B. NAME OF REGISTRAR [Signature]				
25C. FUNERAL DIRECTOR Sol. Levinson & Bros Inc. 6010 Reist. RD									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6850	
BIRTH NO. 67 6850		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Hulda Goodman						2. DATE AND HOUR OF DEATH July 15, 1967 4:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY BALTIMORE					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hosp. of Baltimore						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-13					
						D. STREET ADDRESS (If rural, give location) BELVEDERE TOWERS Apt. 606					
5. SEX Female	6. RACE White Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 12/31/04		9. AGE (In years last birthday) 62		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive				10B. KIND OF BUSINESS OR INDUSTRY Industrial Rental Service		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Julius Pressman						14. MOTHER'S MAIDEN NAME Rosalie?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Robert Goodman - 3 Prince George					
18. 332 X 41 260 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) Ⓡ Cerebral thrombosis DUE TO (B) Arterio Sclerosis DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 13 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 2 19 67 to July 15 19 67 , that (I) (we) last saw the deceased alive on July 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Martin S. Liberman M.D.								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 15, 1967	
23C. PHYSICIAN'S NAME (Type) MARTIN S. LIBERMAN						23D. ADDRESS Sinai Hospital of Baltimore					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE July 16/67		24C. NAME OF CEMETERY or CREMATORY Hebrew Friendship		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.				25C. FUNERAL DIRECTOR Bel Liberman - 2nc - 6010 Reest. Pa			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6851</u>	
BIRTH NO. <u>67 6851</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Snyder Annie W</u>			
2. DATE AND HOUR OF DEATH <u>7-15-67 17:05 A.M.</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>6715 Pimlico Rd. Balt. Co</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Md. 53-00</u> D. STREET ADDRESS (If rural, give location)			
5. SEX <u>F</u>	6. RACE <u>white</u>	7. MARRIAGE STATUS <u>NEVER MARRIED</u> WIDOWED, DIVORCED (specify) <u>Widow</u>		8. DATE OF BIRTH <u>9/7/84</u>	9. AGE (In years last birthday) <u>82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel Weinberg</u>			
14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>212-09-1853A</u>		17. INFORMANT <u>Mr. Louis I. Snyder, 6715 Old Pimlico Road</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <u>422.1 I</u> <u>Antherosclerotic cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 hours</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-15-67</u> 19 to <u>7-15-67</u> 19, that (I) (we) last saw the deceased alive on <u>7-15-</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Samuel B. Bauer</u> M.D., Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>7-15-67</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/16/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Shaarei Zion</u>	
24D. LOCATION (City, town, or county) (State) <u>Rosedale, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 18 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6852	
BIRTH NO. 67 6852		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Brickman, Louis</i>		2. DATE AND HOUR OF DEATH <i>7/14/67 4:10 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i> <i>42</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>4218 Lowell drive #8</i> D. STREET ADDRESS (If rural, give location) <i>Pikesville</i>			
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED <i>DIVORCED</i>	8. DATE OF BIRTH <i>[REDACTED]</i>	9. AGE (In years last birthday) <i>65</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Jacob Brickman</i>		14. MOTHER'S MAIDEN NAME <i>Ida Karklin</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Mrs Edith Kesler - 4218 Lowell</i>	
18. <i>153.8 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Aspiration Pneumonia</i>		<i>4 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Gastro-intestinal Bleeding</i>		<i>10 days</i>	
		(C) <i>Cerebral Damage</i>		<i>4 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Carcinoma of the Colon</i>			
19A. DATE OF OPERATION <i>7/14/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exploratory Laparotomy</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 15</i> 19 <i>67</i> to <i>July 14</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>July 14</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>F. Martinez</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/15/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Ferdinand Martinez</i>		23D. ADDRESS <i>Sinai Hospital of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 16/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Sharon Zion</i>	
24D. LOCATION (City, town, or county) (State) <i>Rosedale, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 18 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Ed Levenson</i>	
				ADDRESS <i>Bus Inc - 6110 West Road</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>67 6853</p> <p>CERTIFICATE OF DEATH</p>		<p>Registered No. 67 6853</p>	
<p>BIRTH NO. 1240</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) MRS. JENNIE SIEGEL</p>		<p>2. DATE AND HOUR OF DEATH 7/14/67 2:35 P.M.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL OF BALTIMORE, BALTIMORE, MARYLAND</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5518 BELLE AVE. #7</p>	
<p>5. SEX FEMALE</p>	<p>6. RACE W</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW</p>	<p>8. DATE OF BIRTH 7/14/1886</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY AT HOME</p>	<p>9. AGE (In years last birthday) 81</p>
<p>11. BIRTHPLACE (State or foreign country) RUSSIA</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME ABRAHAM BAYARSKY</p>		<p>14. MOTHER'S MAIDEN NAME IDA TOBY</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>16. SOCIAL SECURITY NO. UNKNOWN</p>	<p>17. INFORMANT DR. JOSEPH SIEGEL</p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) RENAL INSUFFICIENCY</p>		<p>19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC PYELONEPHRITIS</p>	
<p>20. CAUSE OF DEATH CHRONIC CONGESTIVE HEART FAILURE CHRONIC RECTAL BLEEDING</p>		<p>21. INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p>19A. DATE OF OPERATION 7/11/67</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastrointestinal bleeding</p>	
<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from JUNE 24 1967 to JULY 14 1967, that (I) (we) last saw the deceased alive on JULY 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Wilhelmina Cafugan</p>		<p>23B. DATE SIGNED 7/14/67</p>	
<p>23C. PHYSICIAN'S NAME (Type) DR. KOTZ L.</p>		<p>23D. ADDRESS SINAI HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>		<p>24B. DATE 7/16/67</p>	
<p>24C. NAME OF CEMETERY or CREMATORY PROGRESSIVE RUDOMER VEREIN</p>		<p>24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967</p>		<p>25B. NAME OF REGISTRAR Robert E. Feltner</p>	
<p>25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST, RD.</p>			

7/11/67 2:30 PM

Mrs. Jennie Siegel

MARYLAND

SINAI HOSPITAL AT

BALTIMORE

BALTIMORE

BALTIMORE, MARYLAND

2218 BELLE AVE #2

FRANCE W WIDOW

RUSSIA

ABRAHAM B. BARKER

JOSEPH SIEGEL

RENAL INSUFFICIENCY

CHRONIC PYELONEPHRITIS

CHRONIC RENAL DYSFUNCTION
CHRONIC RENAL DYSFUNCTION

7/11/67

JULY 14 1967
JUNE 24 1967
JULY 14 1967

Abraham B. Barker

Dr. F. C. L.

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

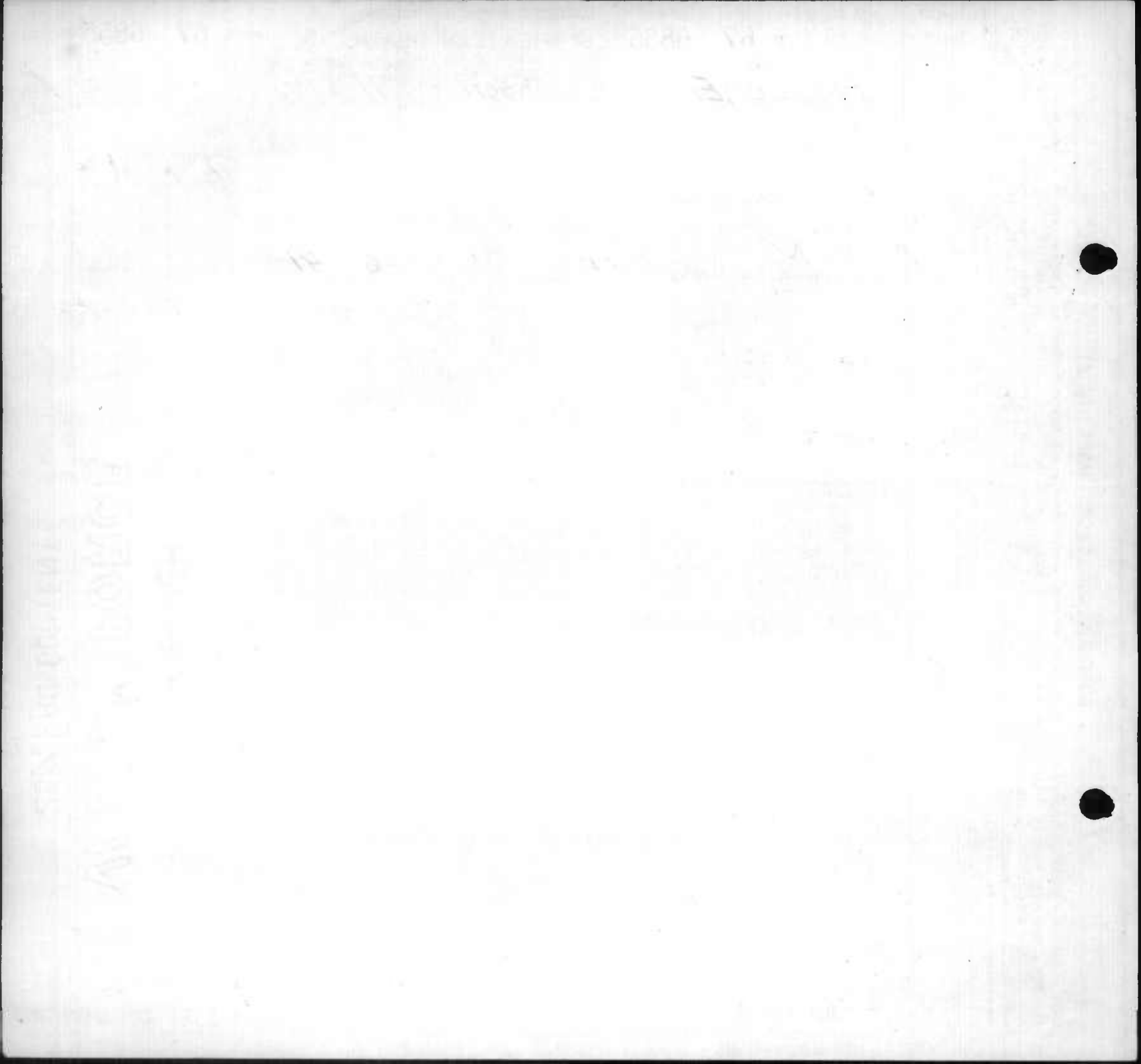
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6854	
BIRTH NO. 432		67 6854	
CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) COLLIDGE, CHARLES		2. DATE AND HOUR OF DEATH 7/14/67 8:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL 36		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 19-03 D. STREET ADDRESS (If rural, give location) 300 S. CALHOUN ST. 21223	
5. SEX M	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 11-11-1911 58 (In year, last birthday)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCCER		10B. KIND OF BUSINESS OR INDUSTRY PROPRIETOR	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL COLLIDGE		14. MOTHER'S MAIDEN NAME MOLLIE XXXXXXXXXX ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. XXXXXXXXXX	
17. INFORMANT HOSPITAL RECORDS		ADDRESS F.S.H.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 217-20-6441 MYO CARDIAL INFARCTION - 2 hours		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic heart disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 14, 1967 to July 14, 1967 , that (I) (we) lost saw the deceased alive on July 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) <u>view the body after death.</u>			
23A. SIGNATURE Hector Feliciano		23B. DATE SIGNED 7-14-67	
23C. PHYSICIAN'S NAME (Type) HECTOR L. FELICIANO		23D. ADDRESS FRANKLIN SQUARE HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/16/67	
24C. NAME OF CEMETERY or CREMATORY WORKMEN CIRCLE		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
 67 6855 **CERTIFICATE OF DEATH** Registered No. 67 6855

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				HOLLEY ERMA ROBINSON		7/16/67 9:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
42 SINAI HOSPITAL OF BALTIMORE				MD B			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE 27-18			
				D. STREET ADDRESS (If rural, give location)			
				3706 BEEHLER AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F	N	MARRIED		5/14/26		41	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				BALTIMORE		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Garrison				Martha Sico			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		213208822		James Holley 3706 Beehler Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
170X I				Ca of Breast			
ANTECEDENT CAUSES				Hypertension			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Interval between ONSET AND DEATH			
				Diagnosed 10/66			
				Many years			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
11/66		Ca of Breast					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/16 19 67 to DOA, 19 67, and that (I) (we) last saw the deceased alive on 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Richard Katon						7/16/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RICHARD KATON				SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-20-67		Baltimore Nat'l. Cem.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 18 1967		Robert E. Faldut		Kelson Funeral Home		1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6856		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6856	
M.E. CASE NO. CARMELA		1. NAME OF DECEASED (Type or Print) MOLLIE A ROMEO			
2. DATE AND HOUR OF DEATH July 17, 1967 2:15 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND			
35 CHURCH HOME AND HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give location) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2020 E PRATT ST			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/19/12	9. AGE (In years last birthday) 55	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) WILINGTON DEL. MARYLAND	12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME ANGLO SCARANO		14. MOTHER'S MAIDEN NAME NICHOLENA SENA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-10-2475		17. INFORMANT LEO JOSEPH ROMEO 2020 E PRATT ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 443X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 9 days	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) CEREBRAL HEMORRHAGE DUE TO			
ANTECEDENT CAUSES		(B) HYPERTENSIVE CARDIOVASC. DIS. DUE TO		YEARS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-9 19 67 to 7-17 19 67, that (I) (we) last saw the deceased alive on 7-17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose S. Veneracion Jr. M.D.				23B. DATE SIGNED July 17, 1967	
23C. PHYSICIAN'S NAME (Type) JOSE S. VENERACION JR. M.D.				23D. ADDRESS CHURCH HOME AND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 20 1967		24C. NAME OF CEMETERY or CREMATORY MORELAND MEMORIAL PARK	
24D. LOCATION TAYLOR AVE BALTO CT MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR THE DIRECTOR BROTHERS INC		25D. ADDRESS 1212 E. CHASE ST			

BY 1828

CHURCH MEMBERS

1828

MEMBERS

1828

MEMBERS

1828

MEMBERS

1828

MEMBERS

MEMBERS

FUNERAL DIRECTOR: IMPORTANT

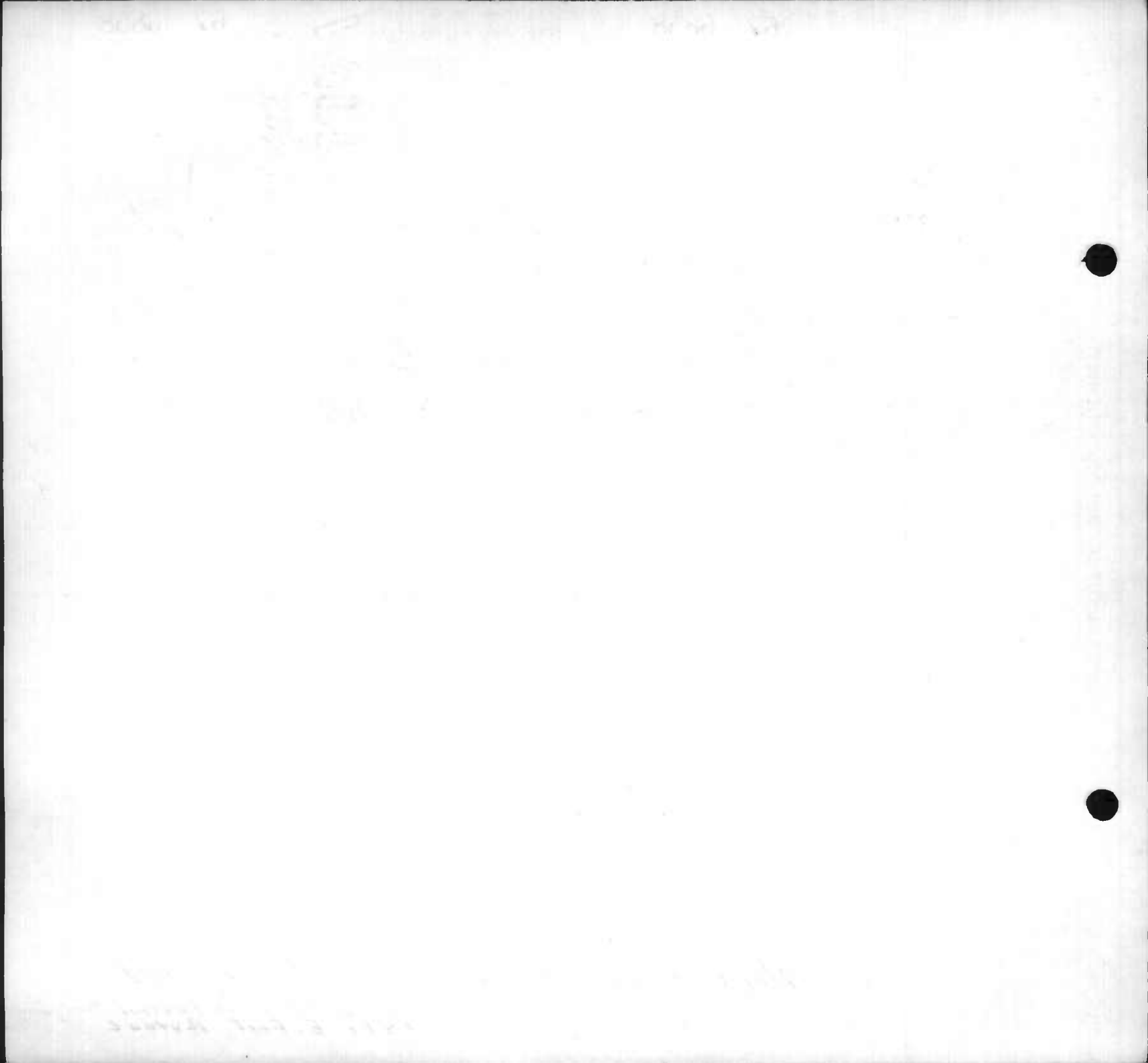
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
67. 6857						Registered No. 67. 6857					
BIRTH NO.						M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Zaetz, Stephen						2. DATE AND HOUR OF DEATH 7/10/67 10:00 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION S. BALTO. GEN. HOSP. 43						A. STATE MARYLAND					
(If not in hospital or institution, give street address or location)						B. COUNTY BALTIMORE					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)						D. STREET ADDRESS (If rural, give location)					
BALTO.						1442 Hull St.					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-5-20	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN			10B. KIND OF BUSINESS OR INDUSTRY STAVEDORES			11. BIRTHPLACE (State or foreign country) POLAND MO.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME MICHAEL Zaetz						14. MOTHER'S MAIDEN NAME MARY - Bohonos					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II 214-12-9854						16. SOCIAL SECURITY NO. 214-12-9854					
17. INFORMANT Mrs. Jeannette Zaetz						ADDRESS 1442 Hull St.					
18. 445X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) INTERAVENTRICULAR HEMORRHAGE						CAUSE OF DEATH (A) INTERAVENTRICULAR HEMORRHAGE DUE TO (B) MALICIOUS HYPERTENSION DUE TO (C) 6 YRS.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. None						INTERVAL BETWEEN ONSET AND DEATH 3 days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 7/9/67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOSTOMY			20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7/7 19 67 to 7/10 19 67 , that (I) (we) lost saw the deceased alive on 7/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Thomas H. Emory						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 7/10/67		
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Buried			24B. DATE 7/14/67			24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.			ADDRESS 1501 E. Fort Avenue.		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6858		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 6858	
1. NAME OF DECEASED (Type or Print) William M. Presser				2. DATE AND HOUR OF DEATH 7-10-67 8:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 24-02	
				C. CITY OR TOWN Baltimore		(If outside city limits, write RURAL and give township)	
				D. STREET ADDRESS 1413 Webster St.		(If rural, give location)	
5. SEX M.	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-2-02	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman + Capt. Retired.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENRY O. Presser				14. MOTHER'S MAIDEN NAME Anna Catherine Allen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-01-9352		17. INFORMANT ADDRESS Lucille Presser 1413 Webster St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 260X I (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DIABETES MELLITIS 2 DUE TO KIMMELSTIEL-WILSON DS. (B) UREMIA 2nd to A DUE TO (C) HASVD 2 DECOMPENSATED CHF.			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that this (this hospital) attended the deceased from 7-6 19 67 to 7-10 19 67 , that we (we) lost saw the deceased alive on 7-10 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John C. Butchart M.D.				23B. DATE SIGNED 7-10-67		23C. PHYSICIAN'S NAME (Type) John C. Butchart M.D.	
23D. ADDRESS 1213 Light St.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 7/14/67		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.			
				ADDRESS 1501 E. Fort Avenue			



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

WILSON THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

July 17, 1967 3:45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

639 Stirling Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

639 Stirling Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

6/15/10

9. AGE (in years
last birthday)

68 57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Emma

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Franklin Seals 3041 Belmont Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) DUE TO Hypertensive Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

July 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

7/19/67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Brooklyn, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 18 1967

Robert E. Fisher, M.D.

Charles A. Rice 661 W. Barre St.



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

KEY, EDWARD

2. DATE AND HOUR OF DEATH

JULY 16, 1967 1245 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

115 Parkin Street 21201

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated

8. DATE OF BIRTH

12-25-10

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Fisherman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Nick

14. MOTHER'S MAIDEN NAME

Mary Square

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 199.21

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) METASTASIS TO BRAIN
DUE TO

1 year

(B) CANCER, SOURCE NOT DETERMINED
DUE TO

not known

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardiovascular Disease

>10 years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/25 1967 to 7/16 1967,
that (I) (we) lost saw the deceased alive on 7/16 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Benjamin Lechner, MD

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/16/67

23C. PHYSICIAN'S
NAME (Type)

Benjamin Lechner

M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 18 1967

25B. NAME OF REGISTRAR

Robert E. Lechner

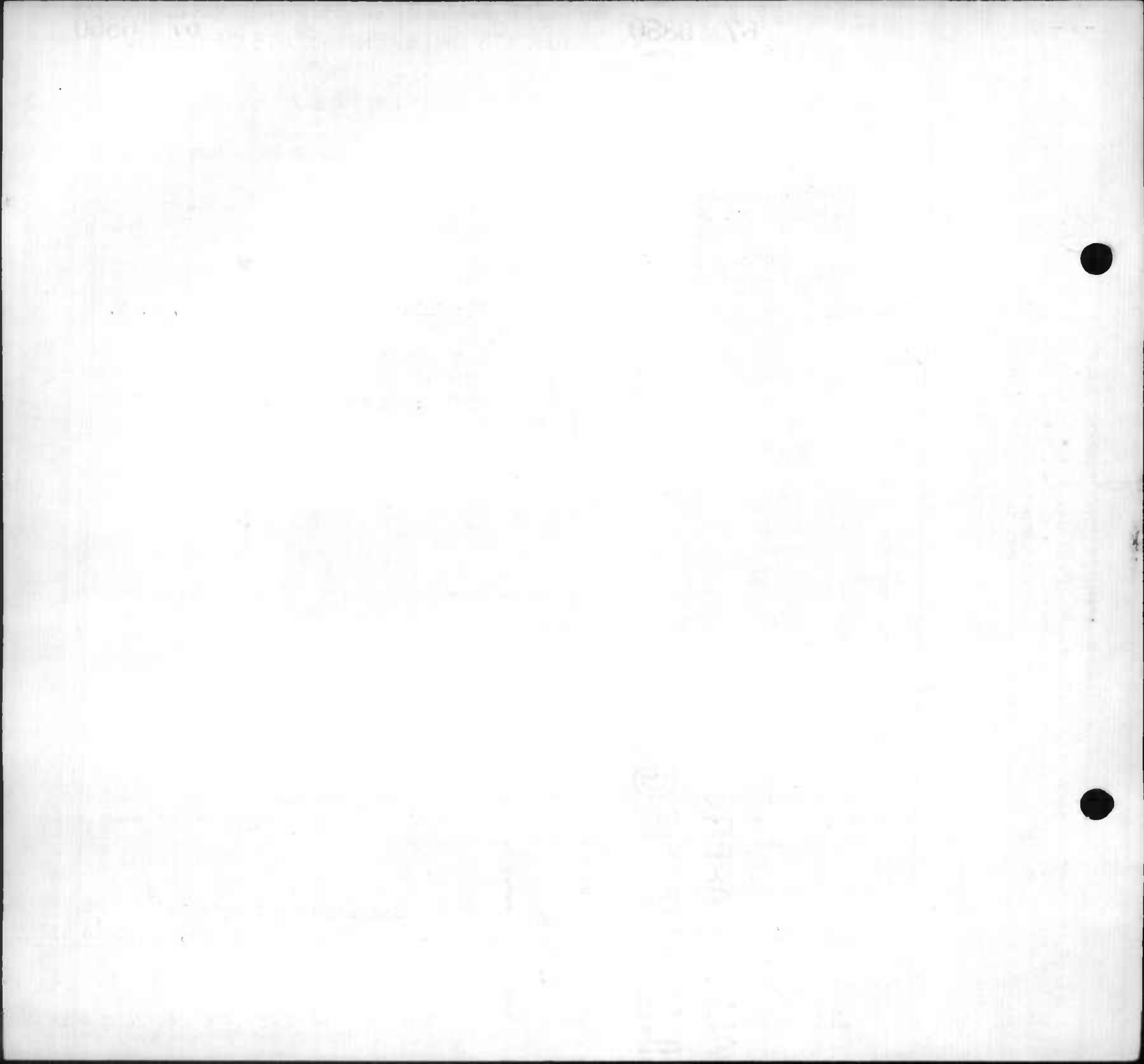
25C. FUNERAL DIRECTOR

Charles A. Rue 661 W Barre St

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6861	
BIRTH NO. 67 6861		CERTIFICATE OF DEATH		7:15 A M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) TAYLOR, Matthew (NMI)		2. DATE AND HOUR OF DEATH July 16, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 13-04		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		D. STREET ADDRESS (If rural, give location) 2809 Woodbrook Ave.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/27/99	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Finisher		10B. KIND OF BUSINESS OR INDUSTRY Grieble Motors		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lewis Taylor		14. MOTHER'S MAIDEN NAME Miranda (Unknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10/23/17 to 5/17/19		16. SOCIAL SECURITY NO. 138-03-7577		17. INFORMANT Records V.A. Hospital, Baltimore, Md. 21218	
18. 260X-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE WEEKS		CAUSE OF DEATH (A) DUE TO CONGESTIVE HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE 5 YEARS			
		(C) DUE TO DIABETIC GLOMERULOSCLEROSIS		UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from February 27, 1967 to July 16, 1967, that (X) (we) last saw the deceased alive on July 16, 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George W. Gaffney		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/17/67	
23C. PHYSICIAN'S NAME (Type) GEORGE W. GAFFNEY, M.D.		23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/20/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.	

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2018-2019
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2022-2023
2024-2025

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-72-61 ED T-3-20		67 6862		BALTIMORE CITY HEALTH DEPARTMENT		67 6862	
BIRTH NO.		67 6862		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.		Margaret M. Thomas		2. DATE AND HOUR OF DEATH		7/17/67 9:40 a.m.	
1. NAME OF DECEASED (Type or Print)		MARGARET M. THOMAS		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Baltimore City Hospital 4940 Eastern Ave. Baltimore, Maryland		Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
5. SEX		Female		6. RACE		White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		Widowed		8. DATE OF BIRTH		12-31-97	
9. AGE (In years last birthday)		69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife	
11. BIRTHPLACE (State or foreign country)		Maryland Baltimore		12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		John Nickol		14. MOTHER'S MAIDEN NAME		Mary Hernbredt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		No		16. SOCIAL SECURITY NO.		216-01-9096	
17. INFORMANT		BCH: Records 4940 Eastern Ave. Baltimore, Md.		ADDRESS		# 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Acute Myocardial Infarct Coma		INTERVAL BETWEEN ONSET AND DEATH		1 day 1 day	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		G.I. bleeding		INTERVAL BETWEEN ONSET AND DEATH		1 day	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		G.I. bleeding		INTERVAL BETWEEN ONSET AND DEATH		1 day	
21A. DATE OF OPERATION		2		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7/16 1967 to 7/17 1967, that (I) lost saw the deceased alive on 7/17 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		Francine Siegal		23B. DATE SIGNED		7/17/67	
23C. PHYSICIAN'S NAME (Type)		FRANCINE SIEGAL		23D. ADDRESS		BCH, 4940 Eastern Ave. Baltimore, Md. # 21224	
24A. BURIAL, CREMATION, REMOVAL (Specify)		Burial		24B. DATE		7-21-1967	
24C. NAME OF CEMETERY or CREMATORY		Sacred Heart		24D. LOCATION (City, town, or county) (State)		Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		JUL 18 1967		25B. NAME OF REGISTRAR		Lilly & Zeiler Inc. 1901-07 Eastern Ave.	

10/10/10

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 67 6863	
BIRTH NO. 67 6863		M.E. CASE NO. 67 6863					
1. NAME OF DECEASED (Type or Print) Peter Lukos				2. DATE AND HOUR OF DEATH 2:15 A.M. July 15, 1967 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Bolton Hill Nursing Home FULL NAME OF (If not in hospital or institution, give street address or location) 90				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01 D. STREET ADDRESS (If rural, give location) 409 Bretton Place			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1873 7 ??	9. AGE (In years last birthday) 94	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? UBA	
13. FATHER'S NAME Louis Lukos				14. MOTHER'S MAIDEN NAME Athena Bonaros			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: Bolton Hill Nursing Home			
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) pneumonitis DUE TO (A) pneumonitis (B) (C) INTERVAL BETWEEN ONSET AND DEATH 2 days							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic cerebro-vascular disease sev. yrs.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-16-66 19 to 7-15-67 19, that (I) (we) lost saw the deceased alive on 7-15-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Ellsworth Cook M.D.				23B. DATE SIGNED 7-15-68			
23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK M.D.				23D. ADDRESS 2431 Maryland Ave. Balto Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/17/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Wm. Cook-Brooks ADDRESS Balt. Md. 21202			

BIRTH NO. 67 6864 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6864

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)PEARLPEARL COLE GUILLOT

2. DATE AND HOUR PRONOUNCED DEAD

July 15, 196710:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)
7-21-672903 N. Calvert Street4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE
Maryland
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2903 N. Calvert Street

5. SEX

Female

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)Widowed

8. DATE OF BIRTH

11/29/069. AGE (In years
last birthday)60If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington D.C.12. CITIZEN OF
WHAT COUNTRY?USA

13. FATHER'S NAME

Fred W. Cole

14. MOTHER'S MAIDEN NAME

Margaret Wagner15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)No16. SOCIAL
SECURITY NO.579-10-4273

17. INFORMANT

John R. Guillot, 5715 N. 57th St. MilwaukeeRobert Pumphrey Funeral Home Rockville, Md.

ADDRESS

Wisc.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TOArteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Werner U. Spitz, M.D.M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐7/16/6723A. BURIAL CREMATION,
REMOVAL (Specify)Removal

23B. DATE

7-17-67- 7-19-67

23C. NAME of CEMETERY or CREMATORY

Valhalla Cemetery

23D. LOCATION

(City, town, or county)

(State)

Milwaukee, Wisconsin
Rockville, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 18 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks Inc. Baltimore, Md. 21202

CHERRY VALLEY KING

VALLEY OF THE
VALLEY OF THE
VALLEY OF THE
VALLEY OF THE

1111

1111

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6865	
BIRTH NO. 67 6865		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) YOUNG, SR. AUGUSTUS			
2. DATE AND HOUR OF DEATH 7-17-67 4-30A		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Balto. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 106 Winters Lane, 31228			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-6-1916	9. AGE (In years last birthday) 51 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitor
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitor		10B. KIND OF BUSINESS OR INDUSTRY Upland Holmes		11. BIRTHPLACE (State or foreign country) Howard Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SAMUEL YOUNG SR.			14. MOTHER'S MAIDEN NAME ELIZABETH YOUNG		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-2983		17. INFORMANT ADDRESS GLADYS YOUNG - 106 WINTERS AVE.	
18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma lung			INTERVAL BETWEEN ONSET AND DEATH !		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastasis in Brain (Rt. hemiplegia) Pneumonia			2 months 15 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-29-1967 to 7-17-1967 , that (I) (we) last saw the deceased alive on 7-17-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anil M. Joshi				23B. DATE SIGNED 7-17-67	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI				23D. ADDRESS Lutheran Hospital of Maryland, 730 Ashburton St. Baltimore - 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/20/67		24C. NAME OF CEMETERY or CREMATORY WESTERN STAR CEM. BALTIMORE CO. MD.	
24D. LOCATION (City, town, or county) Baltimore		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR HERBERT E. NUTTER			

Page 1 of 1
Date: 10/10/10

Subject: [illegible]
Reference: [illegible]

1. [illegible]
2. [illegible]

3. [illegible]
4. [illegible]

5. [illegible]
6. [illegible]

7. [illegible]
8. [illegible]

9. [illegible]
10. [illegible]

11. [illegible]
12. [illegible]

13. [illegible]
14. [illegible]

15. [illegible]
16. [illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6866		CERTIFICATE OF DEATH		67 6866	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LENA M. CLAYVILLE		7/14/67 1:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND			
48 MARYLAND GENERAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 27-09	
		D. STREET ADDRESS (If rural, give location)		1361 PENTWOOD ROAD	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	WHITE	MARRIED	3/23/13	54	NONE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
NONE		Housewife —	PRINCESS ANN, MARYLAND		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
CHARLES CALLAWAY		EFFIE Bowman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-07-5172		Mr. Charles W. Clayville same address	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1		(A) Acute Myocardial Infarction		3 days	
ANTECEDENT CAUSES		(B) ASCUD			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) (R) Hemiplegia 2° to old stroke			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 11, 1967 to July 14, 1967		that (I) (we) last saw the deceased alive on July 13, 1967		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED			
Richard H. Bard M.D.		7/14/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
RICHARD H. BARD M.D.		Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Removal		7/15/67		Odd Fellow Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 18 1967		Robert E. Finkbeiner		William J. Dickner + Sons North - Laurel	

RICHARD H. BARD
Richard H. Bard

✓
7/14/60
Hawkins General Hospital
July 13, 60
July 11, 60
July 10, 60

① Hemiplegia 2 to 4 stroke
HSCUD

Acute Myocardial Infarction 3 days

no

CHARLES CARMAN

HOME

POOR WHITE

MARRIED

PRINCESS ANN, MARYLAND

3/23/13 64

1861 PENTON ROAD

BALTIMORE

MARYLAND

LENA CLAYVILLE

7/14/60

07 0505

07 0505

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6867	
BIRTH NO. 67 6867		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Lillian M. Forrest		July 11, 1967 1:30 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New York B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 327 North Charles Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Garden City - South V-29	
		D. STREET ADDRESS (If rural, give location) 685 4th Place 11530	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 24, 1876
9. AGE (In years last birthday) 90		10. CITIZEN OF WHAT COUNTRY? Maryland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - School Teacher		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Peterson		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-24-7604	
17. INFORMANT Mrs. Arthur Hasler same address		ADDRESS	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Immediately	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertensive cardiovascular disease DUE TO About 9 Yrs.	
(C) Advanced age			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from September 1954 to July 11, 1967 , that (I) (we) last saw the deceased alive on June 29, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Ernest G. Marr</i> M.D.		23B. DATE SIGNED 7/13/67	
23C. PHYSICIAN'S NAME (Type) Ernest G. Marr, M.D.		23D. ADDRESS 516 Cathedral St., Baltimore, Md. 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/14/1967	24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	24D. LOCATION (City, town, or county) (State) Woodlawn, Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967	25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>	25C. FUNERAL DIRECTOR <i>Wm. F. Fisher & Son North & Pa.</i>	

1988 50

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1988 50

67 6868

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 6868

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ELLIOTT, CHETWOOD

2. DATE AND HOUR OF DEATH

7/16/67

11 19 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND Kent

Kent Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

CHESTERTOWN

64-00

D. STREET ADDRESS (If rural, give location)

Country Club Estates

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

10/9/94

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED Executive Real Estate Firm

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Elizabeth, N. J.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN ELLIOTT

14. MOTHER'S MAIDEN NAME

Jesse Orvis Pillin

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War I

16. SOCIAL
SECURITY NO.

006-0129935

17. INFORMANT

ELLIOT
JULIA H. CHETWOOD

ADDRESS

JAME

18. 451X1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

1 7/16/67

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

RUPTURED
AORTIC ANEURYSM

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/16/67 19 to 7/16/67 19
that (I) (we) last saw the deceased alive on 7/16/67 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stephen A. Bennett M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/16/67

23C. PHYSICIAN'S
NAME (Type)

HARVEY BENNETT

M.D.

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Re moval

24B. DATE

7/20/1967

24C. NAME OF CEMETERY or CREMATORY

Greenwood Union Cemetery

24D. LOCATION

(City, town, or county)

Rye, N. Y.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 18 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Wm. J. Lickner & Sons 2800 North Ave. Baltimore, Md.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

Released on app. by Mr. Spitz M.E.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6869				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6869	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) EDITH McMANUS LEILICH				7-13-67 12:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION Memorial Hosp.		(If not in hospital or institution, give street address or location)		A. STATE md.		B. COUNTY	
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow		8. DATE OF BIRTH 1-15-88	
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
10A. Housewife		10B. KIND OF BUSINESS OR INDUSTRY		Maryland		USA	
13. FATHER'S NAME Robert B. McMANUS				14. MOTHER'S MAIDEN NAME MAUDE MORSE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-18-9948		17. INFORMANT (SON) Geo. Leilich	
18. 457X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Perforated Thoracic Aneurysm				19. ASCVD DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ADDRESS 600 Worcester Rd. Towson Md.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH Manual Jimmy M.D.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 6 19 67 to July 13 19 67 , that (I) (we) last saw the deceased alive on July 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frank Palmisano M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-13-67	
23C. PHYSICIAN'S NAME (Type) FRANK PALMISANO, JR., M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7/17/1967		24C. NAME OF CEMETERY or CREMATORY Arlington National Cemetery		24D. LOCATION (City, town, or county) (State) Arlington, Va.	
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR Wm. Leitch & Sons			
				ADDRESS Balto. Md.			

Received from
D. 928

John J. [unclear]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6870		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6870	
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Robert I. Peltz		July 14, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 2218 Lake Avenue			A. STATE Maryland B. COUNTY		
(If not in hospital or institution, give sheet address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2218 Lake Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 8, 1900	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing director		10B. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William C. Peltz		14. MOTHER'S MAIDEN NAME Mary Sudmeier	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Elizabeth Peltz, 2218 Lake Ave.	
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>Atherosclerotic Heart Disease</i> DUE TO (C) <i>Hypertensive C-V Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr -</i> <i>?</i> <i>2 + years</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Atherosclerotic basilar artery insufficiency</i>			<i>2 yrs -</i>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 1965</i> to <i>July 14 1967</i> , that (I) (we) lost saw the deceased alive on <i>July 7 1967</i> and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Samuel T. R. Revell, Jr.</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>July 14, 1967</i>
23C. PHYSICIAN'S NAME (Type) Samuel T.R. Revell, Jr.			23D. ADDRESS M.D. University Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 7/17/67		24C. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR <i>Robert E. Fairburn</i>	
25C. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road,		ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital; except where the physician who pronounced death was in regular attendance on the deceased prior to death; and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 6871

BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		George F. Schone, Sr.,		July 15, 1967 10 ⁰⁰ A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
4626 Belair Road, 00				Maryland	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore 27-01	
				D. STREET ADDRESS (If rural, give location)	
				4626 Belair Road	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Widowed	August 21, 1882	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Fireman		Bethlehem Steel Co.		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
J. Harman Schone			Louise Hofstetter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Robert P. Schone 4626 Belair Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) <i>Atypical Pneumonia</i>		5 days
ANTECEDENT CAUSES			(B) <i>Multiple Sclerosis</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from 7/10/1967 to 7/15/1967, that (I) (we) last saw the deceased alive on 7/10/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Albert B. Bradley</i>				7/17/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Albert B. Bradley		4900 Belair Road			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/18/67		Moreland Park	
				24D. LOCATION (City, town, or county) (State)	
				Parkville, Md.	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 18 1967		<i>Robert E. Salisbury</i>		Ullrich Funeral Home 4210 Belair Road.	

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6872	
BIRTH NO. 67 6872					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) G RACE ROEMER			2. DATE AND HOUR OF DEATH 7-15-1967 5:40 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSP. BALTO. - MD.			A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 513 N. COLLINGTON AVE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH MAY 10-1904	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME OSCAR MELI			14. MOTHER'S MAIDEN NAME JOSEPHINE GIORDANO		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. PIR-07-5717	17. INFORMANT ADDRESS ROBT. W. GAVER 41304 GREENHILL		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.) Carcinoma of Colon			INTERVAL BETWEEN ONSET AND DEATH 10 Mos.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that it (this hospital) attended the deceased from 3-27 19 67 to 7-15 19 67 , that it (we) last saw the deceased alive on 7-15 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) not view the body after death.					
23A. SIGNATURE Irving L. Cooperstein M.D.				23B. DATE SIGNED 7-15-67	
23C. PHYSICIAN'S NAME (Type) IRVING L. COOPERSTEIN M.D.				23D. ADDRESS MONTEBELLO HOSPITAL, BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/18/67		24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS	
24D. LOCATION (City, town, or county) (State) BROOKLYN MD		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOME - 4710 BELAIR			

DATE - 11/10/19

Location - Green

No

1-12-19

Irving L. Cooper, Jr. & Son
General Contractors

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6873	
BIRTH NO. 67 6873		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 7/15/67 18:55 A.M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Daniel Bookhart			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Bar-Wil-Ba Convalescent Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 1925 E. Lafayette Ave	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11/22/1865	9. AGE (In years last birthday) 101	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor-Missionary		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Daniel Bookhart		14. MOTHER'S MAIDEN NAME Viola Wooden		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-34-8284		17. INFORMANT Records	
18. 443X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) Hypertensive arteriosclerotic C.V.D.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-13-1967 to 7-15-1967 , that (I) (we) last saw the deceased alive on 7-12-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.R. Campbell				23B. DATE SIGNED 7-15-67	
23C. PHYSICIAN'S NAME (Type) C.R. Campbell		23D. ADDRESS 1618 W. North Ave. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 19/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) Arbutus Md		25A. DATE REC'D BY HEALTH DEPT. JUL 18 1967		25B. NAME OF REGISTRAR Robert E. Fabela, M.D.	
25C. FUNERAL DIRECTOR Frank T. Falcikowski		25D. ADDRESS 129 N. ...			

Hydrogenous otosclerosis
C.V.D.

10

C.R. Campbell
C.R. Campbell

7-12-12
1-12-12
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21-1-12
1-12-12

1518 W. North Ave. Baltimore Md.

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67 6874

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6874

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **JAMES** **MARYLAND** 2. DATE AND HOUR PRONOUNCED DEAD **July 15, 1967** **11:20 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) **Maryland**

5. SEX **Male** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Married** 8. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

9. AGE (In years last birthday) **68** 10. STREET ADDRESS (If rural, give location) **1521 N. Chapfe Street**

11. BIRTHPLACE (State or foreign country) **Rocky Mt. N.C.** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **John Maryland** 14. MOTHER'S MAIDEN NAME **Mary**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT **Raisey Johnson 1021 Milton Ave.**

18. **E 802X** CAUSE OF DEATH **Multiple Injuries** INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Rail Road Track #4** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **Monument and Kresson Streets**

21D. TIME OF INJURY (APPROX.) **July 15, '67 10:01 A.M.** 21E. INJURY OCCURRED **WHILE AT WORK** 21F. HOW DID INJURY OCCUR? **subject struck by train 26-44**

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Werner U. Spitz, M.D.** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **7/16/67** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **July 18/67** 23C. NAME OF CEMETERY or CREMATORY **mt Calvary Cem.** 23D. LOCATION (City, town, or county) (State) **A.A. County Md**

24A. DATE REC'D BY HEALTH DEPT. **JUL 18 1967** 24B. NAME OF REGISTRAR **John E. Johnson** 24C. FUNERAL DIRECTOR **Milton E. Ellickson 11297 Cadmus St**

N 869.2

Received

John M. Murphy

Dec 22 1894

Rocky Mt. N.C.

Money

Amount of money

Received

John M. Murphy

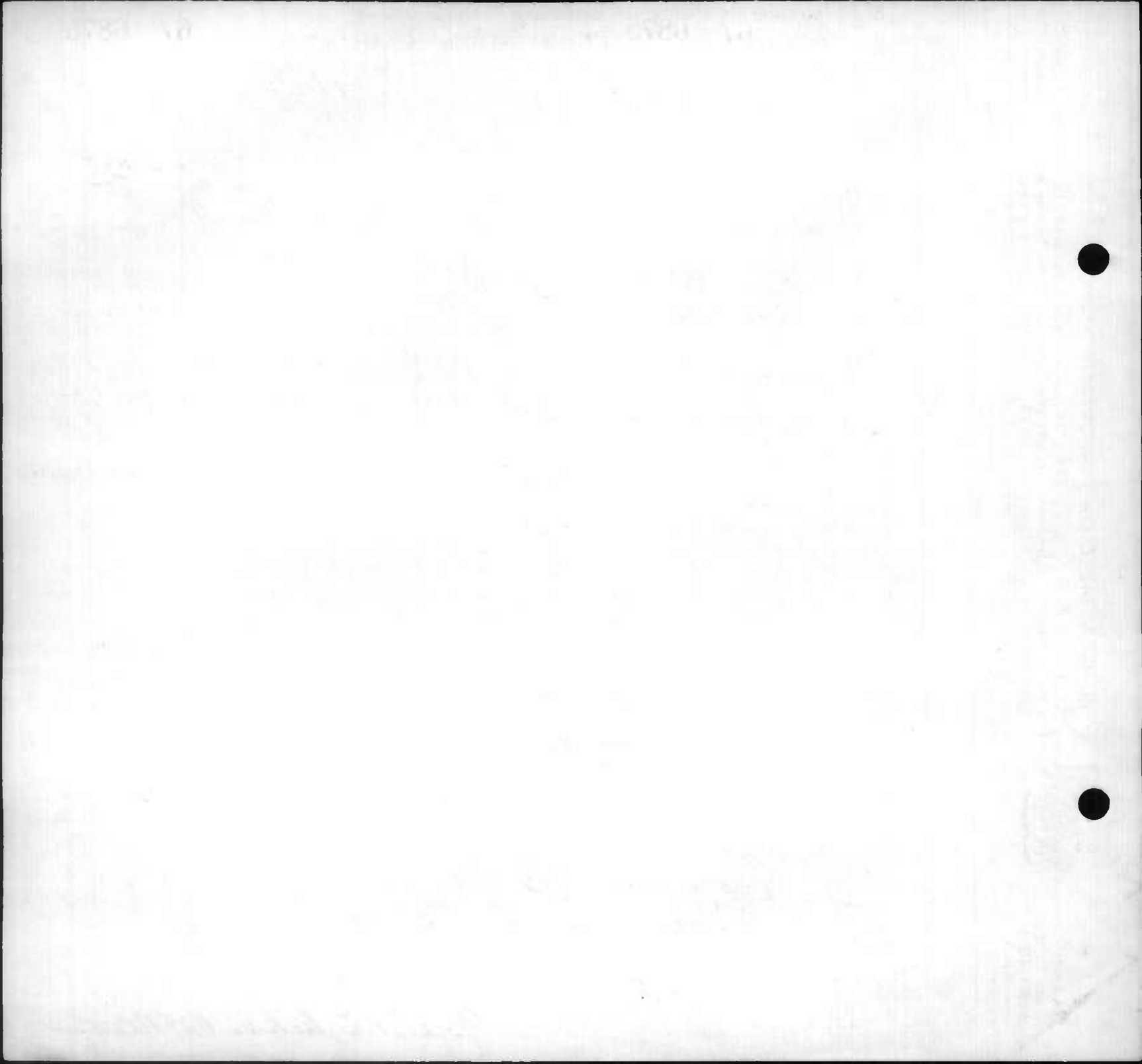
Dec 22 1894

Rocky Mt. N.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6875	
BIRTH NO. 67 6875		CITIZENSHIP OF DEATH		Registered No. 67 6875	
1. NAME OF DECEASED (Type or Print) <i>Emanuel Gray</i>		2. DATE AND HOUR OF DEATH <i>7/18/67 at 2 A.M.</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>002016 N. Wolfe St</i>		C. CITY OR TOWN (If outside city limits, write R.U.R. and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>2016 N. Wolfe St</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>3/17/10</i>	9. AGE (in years last birthday) <i>57</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer American Sugar Refining</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
13. FATHER'S NAME <i>Frank Gray</i>		14. MOTHER'S MAIDEN NAME <i>Lula Coleman</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>237-12-3327</i>		17. INFORMANT <i>Wife</i> ADDRESS <i>2016 N. Wolfe St</i>	
18. <i>15-0X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Terminal Carcinoma of Esophagus</i>		<i>Approx 1 year</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>August 1966</i> to <i>17th July 1967</i> , that (I) (we) last saw the deceased alive on <i>7/15 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alvin Thompson</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/18/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Alvin Thompson</i>		23D. ADDRESS <i>1856 N. Wolfe St</i>			
24A. BURIAL CREMATION, REMOVAL (specify) <i>Burial</i>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <i>Crown Hill Park</i>	
				24D. LOCATION (City, town, or county) (State) <i>Sever, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 18 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR <i>Yonah E. Finkbeiner 1129 N. Carroll St</i>	



67 6876 CERTIFICATE OF DEATH

Registered No.

67 6876

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JACOB ROYAL

2. DATE AND HOUR OF DEATH

7/18/67

1 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

BALTIMORE
421 N. Pine St.

5. SEX

M

6. RACE

N

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

separated

8. DATE OF BIRTH

5/12/1911

9. AGE (In years
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

unemp.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Halifax Co. Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William D. Royal

14. MOTHER'S MAIDEN NAME

Mary Stewart

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

16. SOCIAL
SECURITY NO.

218-01-4667

17. INFORMANT

Joseph D. Royal 120-12 170th St
Jamaica Queens

ADDRESS

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CARDIAC ARREST
DUE TO(B) CHRONIC LUNG DISEASE
DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

1/2 HR.

5 YRS.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

CHRONIC ALCOHOLISM

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that my (this hospital) attended the deceased from JAN-17 1962 to JULY 18 1967,
that (I) we last saw the deceased alive on JULY 17 1967 and that in (my) last opinion death occurred on the date
and hour and from the causes stated above. (I) we (did) did not view the body after death.

23A. SIGNATURE

Gary N. Wilner MD.

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

July 18, 1967

23C. PHYSICIAN'S
NAME (Type)

GARY N. WILNER

23D. ADDRESS

M.D. UNIVERSITY HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

Family Plot

24D. LOCATION

(City, town, or county)

(State)

Halifax Co. Virginia

25A. DATE REC'D BY HEALTH DEPT.

JUL 19 1967

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Crawford Funeral Home

ADDRESS

Halifax Co. Va

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the Chief Medical Examiner. Also, if the direct or contributing cause of death

the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death

shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased

was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the

deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such

written approval must be obtained before the remains are embalmed or final disposition is made.

M. E. released to U. H. by Robert E. Jackson July 18, 1967 3:45 P.M. On Baltimore Medical Examiner's Office for R-400

[Faint, illegible text, likely bleed-through from the reverse side of the page]

1
B-620

67 6877

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6877

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RUTH BROOKS

2. DATE AND HOUR PRONOUNCED DEAD

July 17, 1967 9:50 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4612 Lawn Park Road

5. SEX

Female

6. RACE

White

7. MARRIED, ~~NEVER MARRIED~~
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

7-23-1888

9. AGE (In years
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

BENJAMIN BROOKS

14. MOTHER'S MAIDEN NAME

MARY BOND

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; if yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

-

17. INFORMANT

ADDRESS

JULIA BROOKS 4612 LAWN PARK RD

18. E8164

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple recent traumatic
DUE TO injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Edmondson Ave. and Swann Ave.

21D. TIME
OF INJURY
(APPROX.)

7 17 67 7:25 A.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-20-67

23C. NAME OF CEMETERY OR CREMATORY

WOODLAWN CEMETERY BALTO

23D. LOCATION

(City, town, or county)

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 19 1967

R. S. Fisher, M.D.

WEBER FUNERAL HOME 5311 EDMONDSON AVE

7-27-1972

MASTERS

MARK GORD

100-100000

100-100000

MASTERS

MARK GORD

100-100000

100-100000

100-100000

7-27-1972

100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6878	
BIRTH NO. 67 6878		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) MOOREFIELD MAY			2. DATE AND HOUR OF DEATH 7/15/67 1:40 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE, INC. 42			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Carroll Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) WESTMINSTER Finksburg 56-00 D. STREET ADDRESS (If rural, give location) Rt #1 FINKSBURG		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/29/34	9. AGE (In years last birthday) 32	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND, U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN HYTT SULLIVAN			14. MOTHER'S MAIDEN NAME JENNIE MAE SHEAFFER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-34-3137	17. INFORMANT JANE MERSHON ADDRESS 5406 Northwood DRIVE BALTIMORE, Md. 21212		
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Adeno carcinoma of BREAST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. UNKNOWN			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/6/67 19 to 7/15/67 19, that (I) (was) lost saw the deceased alive on July 15, 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald Schachar M.D.				23B. DATE SIGNED 7/15/67	
23C. PHYSICIAN'S NAME (Type) RONALD SCHACHAR		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/19/67	24C. NAME OF CEMETERY or CREMATORY Stone Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Maryland.	
25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		25B. NAME OF REGISTRAR Robert E. Fadden, MA		25C. FUNERAL DIRECTOR ADDRESS H. J. Eckhardt Owings Mills, Md.	

217-24-3127

Frankford

Carnell Co.

H. J. Eblen & Company, Inc.
Pittsburgh, Pa.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6879	
BIRTH NO. 4-1-50		67 6879		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARGARETE HASSON		2. DATE AND HOUR OF DEATH 7-14-67 2:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY CECIL C.			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CHILDS 21916 57-00			
		D. STREET ADDRESS (If rural, give location)			
5. SEX Female	6. RACE CAU	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-30-11	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY Union Hospital		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALEXANDER KIRKPATRICK		14. MOTHER'S MAIDEN NAME CAROLINE DIERLING	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-3158		17. INFORMANT Wilmer R. Hasson, Childs, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 593X I		CAUSE OF DEATH CARDIAC ARREST		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO CHRONIC RENAL FAILURE		5 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7-3-1967 to 7-14-1967 , that (I) (we) last saw the deceased alive on 7-14-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE G. Michael Vincent M.D.		23B. DATE SIGNED 7-14-67		23C. PHYSICIAN'S NAME (Type) G. MICHAEL VINCENT M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/17/67		24C. NAME OF CEMETERY or CREMATORY Asbury Meth. Cemetery		24D. LOCATION (City, town, or county) (State) Port Deposit, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		25B. NAME OF REGISTRAR Robert E. Janney, Jr.		25C. FUNERAL DIRECTOR Ralph E. Hicks	
		ADDRESS Hicks Home for Funerals, Elkton, Md.			

05-1978

05-1978

05-1978

05-1978

05-1978

05-1978

05-1978

05-1978

05-1978

05-1978

69-57-19ED 1

P-412

67 6880

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 6880

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Lillian M Phillips

2. DATE AND HOUR OF DEATH

7/13/67

16³⁵ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6317 Elliott St.

21224 007

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

11-2-82

9. AGE (In years
last birthday)

85

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Lloyd

14. MOTHER'S MAIDEN NAME

Louise Bull

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218 07 79405

17. INFORMANT

ADDRESS

BCH: Records 4940 Eastern Ave. Baltimore, Md. #21224

18. 4 20 11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Congestive Heart Failure 2 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) ASCVD 20 yrs.

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

M.I.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (nately medical examined)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/26 1967 to 7/13 1967,
that (I) (we) last saw the deceased alive on 7/13 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. M. Levinsohn

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/13/67

23C. PHYSICIAN'S
NAME (Type)

E. M. Levinsohn

M.D.

23D. ADDRESS

4940 Eastern Ave. Baltimore, Maryland # 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-17-67

24C. NAME OF CEMETERY or CREMATORY

Lorraine Park

24D. LOCATION

Woodlawn Belto Co Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 19 1967

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

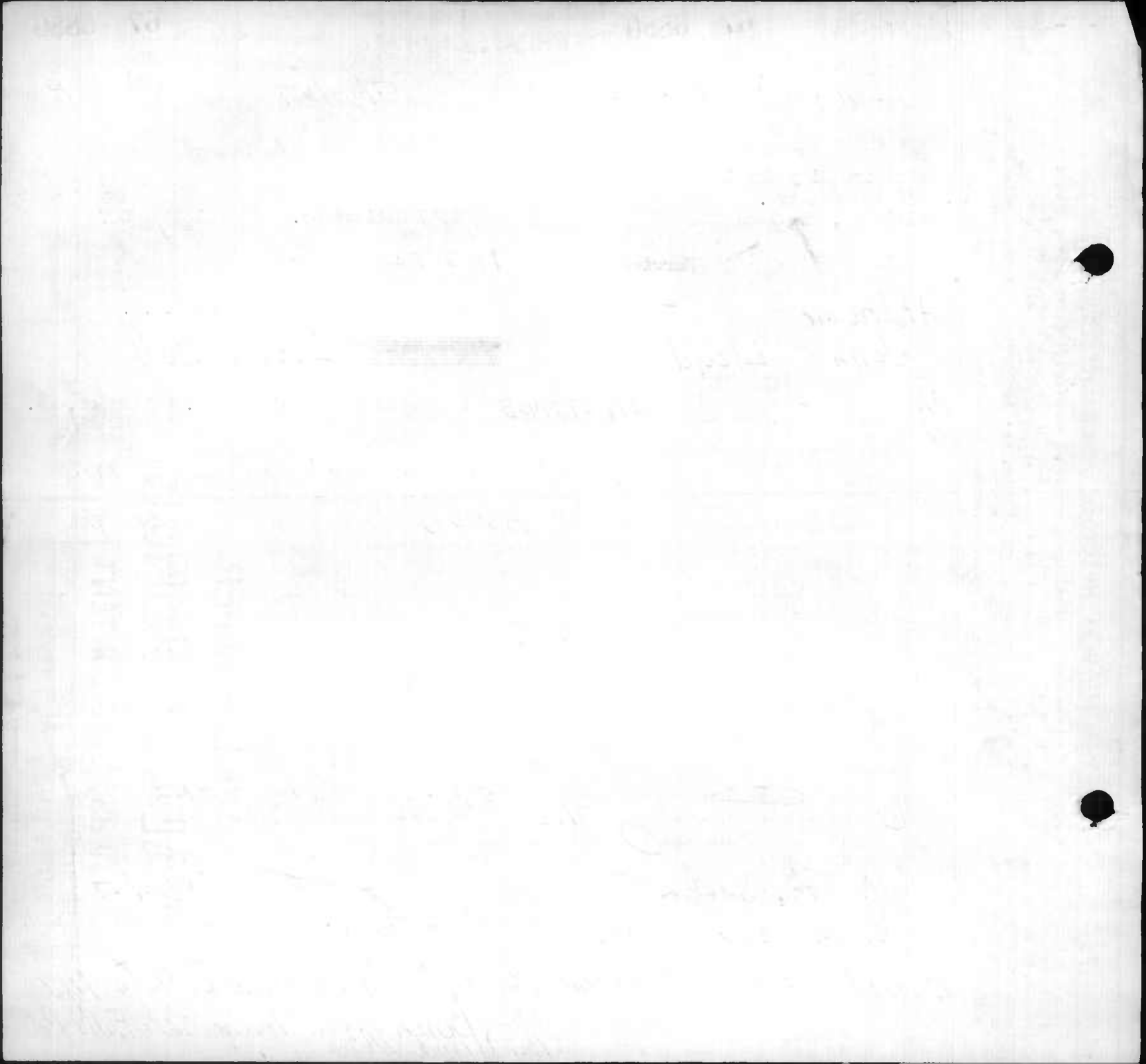
Burger Funeral Home 3631 Falls Rd

ADDRESS

By N. A. M. Burger, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.



BIRTH NO.

M.E. CASE NO.

67 6881

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6881

1. NAME OF DECEASED

(Type or Print)

CARRIE

Burns

COLE

2. DATE AND HOUR PRONOUNCED DEAD

July 14, 1967

4:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3660 Falls Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3660 Falls Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Nov 27 1879

9. AGE (In years
last birthday)

85

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William H Burns

14. MOTHER'S MAIDEN NAME

Tibitha Appleby

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

-

17. INFORMANT

Dr Milton B. Cole 11801 New Hampshire Ave.

ADDRESS Silver Spring, Md

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/15/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-18-67

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cem

23D. LOCATION

Baltimore Md

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1967

24B. NAME OF REGISTRAR

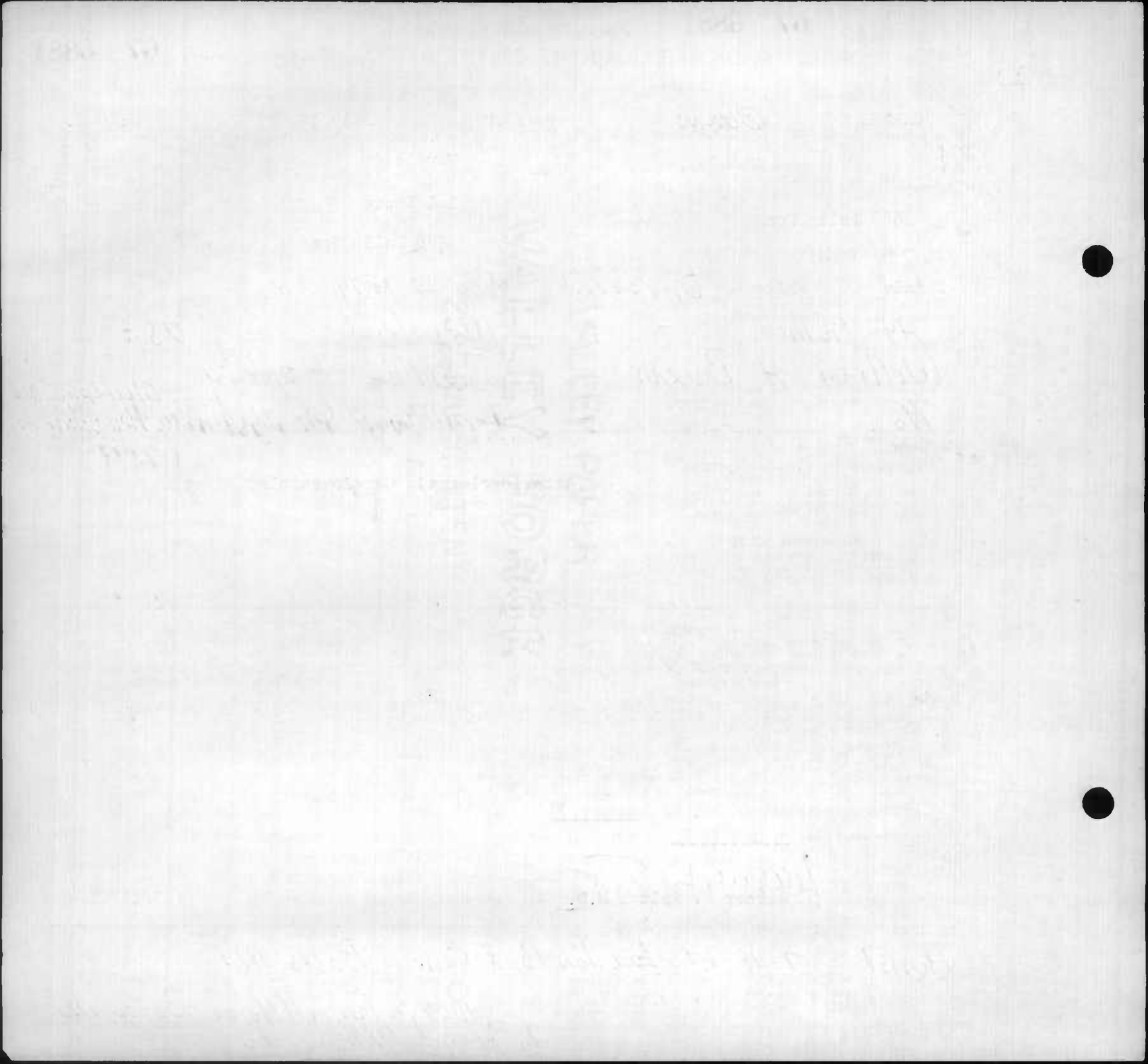
Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Burgess Funeral Home Baltimore Md

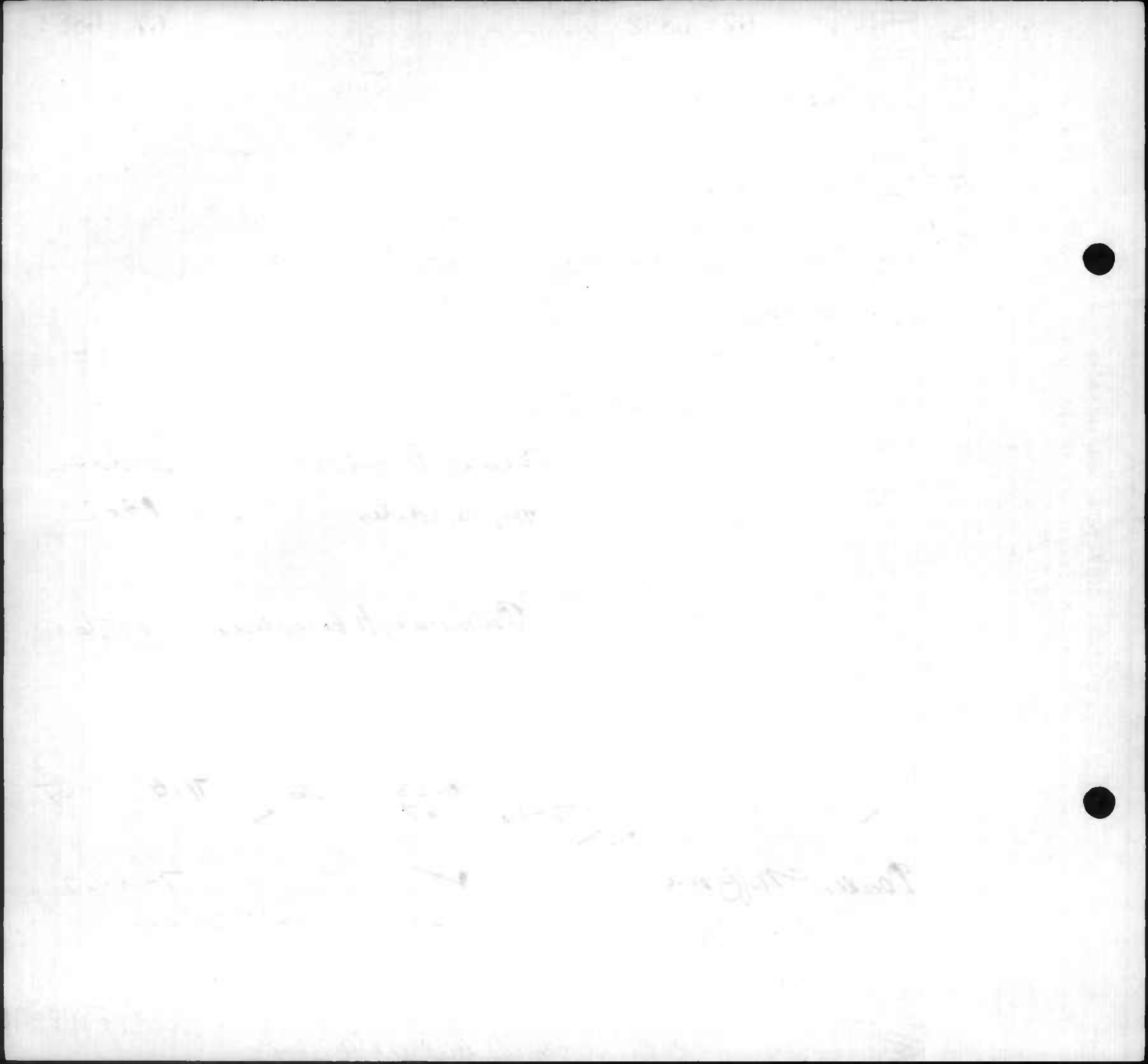
ADDRESS

by Harold H. Burgess Jr



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6882 CERTIFICATE OF DEATH					Registered No. 67 6882				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Richard Asbury Davis</u>					2. DATE AND HOUR OF DEATH <u>July 16, 1967</u> <u>3</u> <u>P</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>D.O.A. Sinai Hospital</u>					A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
					D. STREET ADDRESS (If rural, give location) <u>2023 Druid Park Drive</u>				
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>July 4, 1889</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months Days Hours Min.		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Heavy Equip.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Peter Davis</u>					14. MOTHER'S MAIDEN NAME <u>Mary Virginia Lindsay</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>219 05 5276A</u>		17. INFORMANT <u>Viola M. Davis</u>			ADDRESS <u>same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>420117-002.1</u> (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <u>Cerebral Thrombosis</u> DUE TO (B) <u>myocarditis</u> DUE TO (C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<u>Pulmonary tuberculosis</u>				
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>11-23</u> 19 <u>56</u> to <u>7/16</u> 19 <u>67</u> , that (I) was lost saw the deceased alive on <u>7-16</u> 19 <u>67</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) view the body after death.									
23A. SIGNATURE <u>Reuben Hoffman</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>7-18-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Reuben Hoffman</u>					23D. ADDRESS <u>846 W. 36th Street</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 19, 1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 19 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>		ADDRESS <u>3631 Falls Rd.</u>		



67 6883

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 62-17068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6883

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) BENJAMIN--NAPARSTEK Charles Benjamin Naparstek				2. DATE AND HOUR PRONOUNCED DEAD July 16, 1967 6:15 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CITY HOSPITAL D.O.A. 7-25-67				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2110 Aliceanna Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) CHILD	8. DATE OF BIRTH JULY 3, 1962	9. AGE (In years last birthday) 5	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD			10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES NAPARSTEK			14. MOTHER'S MAIDEN NAME CLEMENTINE T4TIN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. No		17. INFORMANT ADDRESS CLEMENTINE NEPARSTEK 2110 ALICEANNA ST. BALD. MD. 21231		
18. E929.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Drowning ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ---				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ---							
19A. DATE OF OPERATION ---		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ---	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Water		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Front of 506 Seneca Park Road Essex			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7 16 67 4-5:45		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Subject drowned			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicida <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. EXAMINER'S NAME (Type) DATE SIGNED July 17, 1967							
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 7-19-67		23C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS CEM.		23D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
24A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		24B. NAME OF REGISTRAR R. E. Fisher, M.D.		24C. FUNERAL DIRECTOR ADDRESS W. FIALKOWSKI 2007 EASTERN AVE. BALTO. MD. 21231			

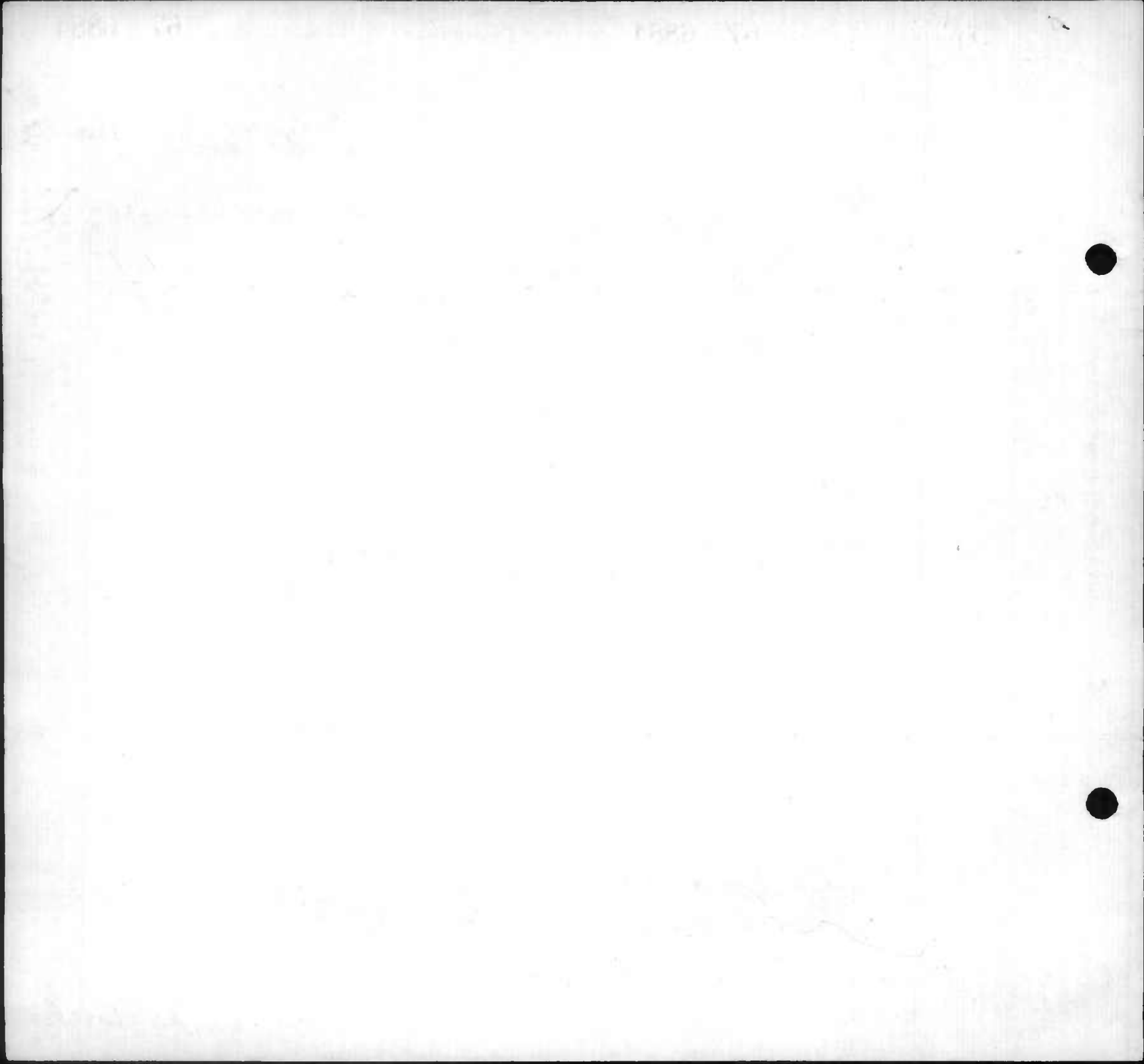
RECEIVED

WILLIAM H. FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6884	
P-400 BIRTH NO. 67-1477667 6884		CERTIFICATE OF DEATH	
M.E. CASE NO. 67-1477667 6884		1. NAME OF DECEASED (Type or Print) Baby Boy Powell	
2. DATE AND HOUR OF DEATH 4-12-67 10:25 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Box 1 B. COUNTY Judwood Lane, Balt. MD 23		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 53-00	
D. STREET ADDRESS (If rural, give location) Box 1 Judwood Lane Balto MD 23		5. SEX Male 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) -	
8. DATE OF BIRTH 4-18-67 9. AGE (In years last birthday) 1 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - 10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clyde Powell 14. MOTHER'S MAIDEN NAME Shirley		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - 16. SOCIAL SECURITY NO. - 17. INFORMANT Mother ADDRESS -	
18. 762.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Anoxia DUE TO (B) Cerelectasis DUE TO (C) Summation		INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 6 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 4-11-67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) - 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? -		22. I certify that (I) (this hospital) attended the deceased from 4-11-67 to 4-12-67 that (I) (we) lost saw the deceased olive an 4-12-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Robert C. Irwin M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED 4-12-67		23C. PHYSICIAN'S NAME (Type) Robert C. Irwin M.D. 23D. ADDRESS Bon Secours Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 4/14/67 24C. NAME OF CEMETERY OR CREMATORY St Peter Cem 24D. LOCATION (City, town, or county) (State) Balto Md		25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. 25C. FUNERAL DIRECTOR Thomas J. Kennedy ADDRESS Balto	



67 6885

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6885

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DANIEL SALA

2. DATE AND HOUR PRONOUNCED DEAD

July 14, 1967 9:14 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

730 Bethel Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

730 Bethel Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

2-14-91

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Equip. Operator.

10B. KIND OF BUSINESS OR INDUSTRY

Road Building

11. BIRTHPLACE (State or foreign country)

Mass

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Chesro Sala

14. MOTHER'S MAIDEN NAME

Theodoro Cortni

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

WWI

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Chrsro J. Sala, Fair Haven, Mass.

18. 465X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive bilateral pulmonary
DUE TO embolism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

July 14, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-18-67

23C. NAME OF CEMETERY or CREMATORY

St. Patricks Cem.

23D. LOCATION

(City, town, or county)

Wareham, Mass.

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Wm. E. Johnson, 8521 Loch Raven Blvd.

ADDRESS

Balto. Md. 21204



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6886		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6886	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Duffy MARIE</i>			7/15/67 - 4-45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i>			A. STATE <i>Md.</i> B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO</i>		
			D. STREET ADDRESS (If rural, give location) <i>1347 Githings Ave.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>8-6-83</i>	9. AGE (In years last birthday) <i>83</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO. Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>HARRY Smith</i>			14. MOTHER'S MAIDEN NAME <i>Mary O'Connor</i>		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>Mr. John J. Duffy, 202 Hilton Ave. Catonsville, Md. 21229</i>
18. <i>420111</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial infarction</i>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/10</i> 19 <i>67</i> to <i>7/15</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>7/15</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>K.Y. Kim</i> M.D.				23B. DATE SIGNED <i>7/15/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>KYE YOON KIM</i> M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-19-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 19 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wm. E. Johnson, 8521 Loch Reven Blvd. 21204</i>	

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HONOLULU, HAWAII

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U.S. AIR FORCE
HONOLULU, HAWAII

FUNERAL DIRECTOR: IMPORTANT

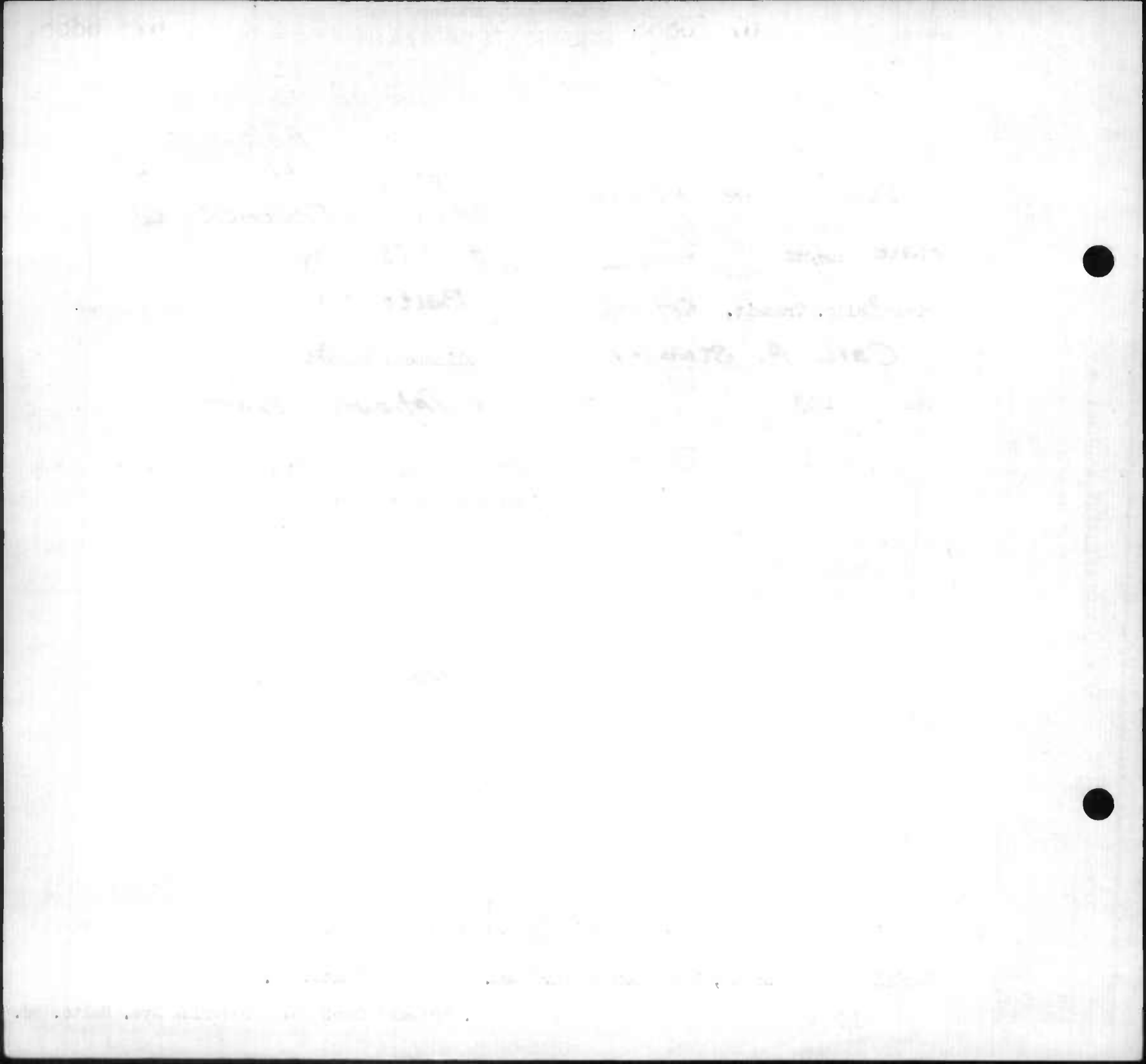
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6887	
BIRTH NO. 67 6887		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM HESS		2. DATE AND HOUR OF DEATH 7/15/67 1:55 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 109 OAKLEY VILLAGE			
5. SEX M	6. RACE CAUCASIAN	7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/17/10	9. AGE (In years lost birthday) 56	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GLASS FACTORY		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HARRY HESS		14. MOTHER'S MAIDEN NAME CORA McLARY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Corinne Hess 109 Oaklee Village Balto. Md.	
18. 410X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) GASTRO-INTESTINAL HEMORRAGE DUE TO (B) CARDIAC CIRRHOSIS DECREASED CLOTTING FACTORS DUE TO (C) RHD & SPE putting in total & Anterior Infarction		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) this hospital attended the deceased from 6/2/67 to 7/15/67 that (1) (we) lost saw the deceased alive on 7/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Barker, Jr. M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/15/67	
23C. PHYSICIAN'S NAME (Type) WILLIAM H. BARKER, JR. M.D.		23D. ADDRESS UNIV. HOSPITAL BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 19, 1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967			
25B. NAME OF REGISTRAR R. E. E. F. Barker		25C. FUNERAL DIRECTOR ADDRESS G. Truman Schwab 3512 Frederick Ave. Balto. Md.			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 6888		CERTIFICATE OF DEATH		Registered No. 67 6888		
1. NAME OF DECEASED (Type or Print) AUGUST P. Strasser				2. DATE AND HOUR OF DEATH July 15, 1967 1.25 P.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 316 ST. CAMILLUS 34 BON SECOURS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City D. STREET ADDRESS (If rural, give location) 3433 Old Frederick Rd.						
5. SEX Male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-25-08	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver Balto. Transit.			10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? AMERICAN			
13. FATHER'S NAME Carl A. Strasser				14. MOTHER'S MAIDEN NAME Elizabeth Schmidt						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1918			16. SOCIAL SECURITY NO. -		17. INFORMANT Patients Chart				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.) 292.41 + 002.1				CAUSE OF DEATH (A) DUE TO Aplastic Anemia, etiology unknown (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH unknown		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary TB.										
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from JUNE 27, 1967 to July 15, 1967 , that (I) (we) last saw the deceased alive on July 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE Agustin del Campo. M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 15-1967				
23C. PHYSICIAN'S NAME (Type) AGUSTIN del CAMPO. M.D.				23D. ADDRESS BON SECOURS BALTIMORE MD						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 18, 1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR G. Truman Schwab				ADDRESS 3512 Frederick Ave. Balto. Md.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. W-240		67 6889		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6889	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WHEELEY, NELLIE WINEHOLT				2. DATE AND HOUR OF DEATH 7-16-67 8:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND				A. STATE Maryland B. COUNTY Baltimore Co.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) MARYLAND DUNDUCK 21222			
				D. STREET ADDRESS (If rural, give location) 1807 Snider Ave 53-00			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-1-90	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Leander Wineholt dec.				14. MOTHER'S MAIDEN NAME Lizzie Doster dec.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-48-3721		17. INFORMANT BCH; RECORDS ADDRESS 21224 4940 Eastern Ave. Baltimore, Md			
18. 203X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Myeloma				CAUSE OF DEATH (A) Multiple Myeloma (B) DUE TO (C) DUE TO			
19. 2 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/14/67 19 to 7/11/67 19, that (I) (we) last saw the deceased alive on 7/11/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stewart Leibowitz				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/14/67	
23C. PHYSICIAN'S NAME (Type) Stewart Leibowitz				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE 21224, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/20/67		24C. NAME OF CEMETERY OR CREMATORY MORELAND MEM.		24D. LOCATION (City, town, or county) (State) BALTO. CO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR McArthur Bradley, Dunduck, Md		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6890	
BIRTH NO. 67 6890		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY K. CURRY		2. DATE AND HOUR OF DEATH 7-16-67 1:00 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland Gen. Hosp.			A. STATE Maryland B. COUNTY Anne Arundel Co		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Suburban 52-00		
			D. STREET ADDRESS (If rural, give location) 6 E. 2nd Ave.		
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-5-22	9. AGE (In years last birthday) 45	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Joseph Bodkin			14. MOTHER'S MAIDEN NAME M. Medie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 29-30 9292		17. INFORMANT Mrs. James A. Sweeney ADDRESS Same
18. 387.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute pancreatitis			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronosis					
19A. DATE OF OPERATION 7/11/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritonitis		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-11-1967 to 7-16-1967 , that (I) (we) last saw the deceased alive on 7-16-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nabil F. Warsal M.D.				23B. DATE SIGNED 7-16-67	
23C. PHYSICIAN'S NAME (Type) NABIL F. WARSAL				23D. ADDRESS Maryland Gen. Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 18, 1967		24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Pk.	
		24D. LOCATION (City, town, or county) (State) Dorsey Road & Wash Blvd. Dorsey, Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR George J. Gonce ADDRESS 4001 Ritchie Hwy. (21225)	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6891		CERTIFICATE OF DEATH		67 6891	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mack, Gussie Shields (Augusta)		7-17-67 2:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland			
39 Provident Hospital, Inc. Baltimore, Maryland 21217		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		16-03	
		D. STREET ADDRESS (If rural, give location) 822 N. Mount Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	Negro	Widowed	9-7-1892	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
		None	Virginia, Accomack Co.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
AGUSTUS SHIELDS			UNK.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
		219-30-8398	Lottie Roane 1704 Mosher Street		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury at complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		Cerebrovascular Accident		2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO ASHD & Congestive Heart Failure		2 days	
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-16-67 19 to 7-17-67 19, that (I) (we) last saw the deceased alive on 7-17-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elijah Saunders				23B. DATE SIGNED 7/18/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. E. Saunders		1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-18-67		Carver Memorial Park	
				Laurel, Maryland	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 19 1967		Robert E. Jackson		MORTON & DYETT F.H. 1701 Laurens St.	

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FUNERAL DIRECTOR: IMPORTANT

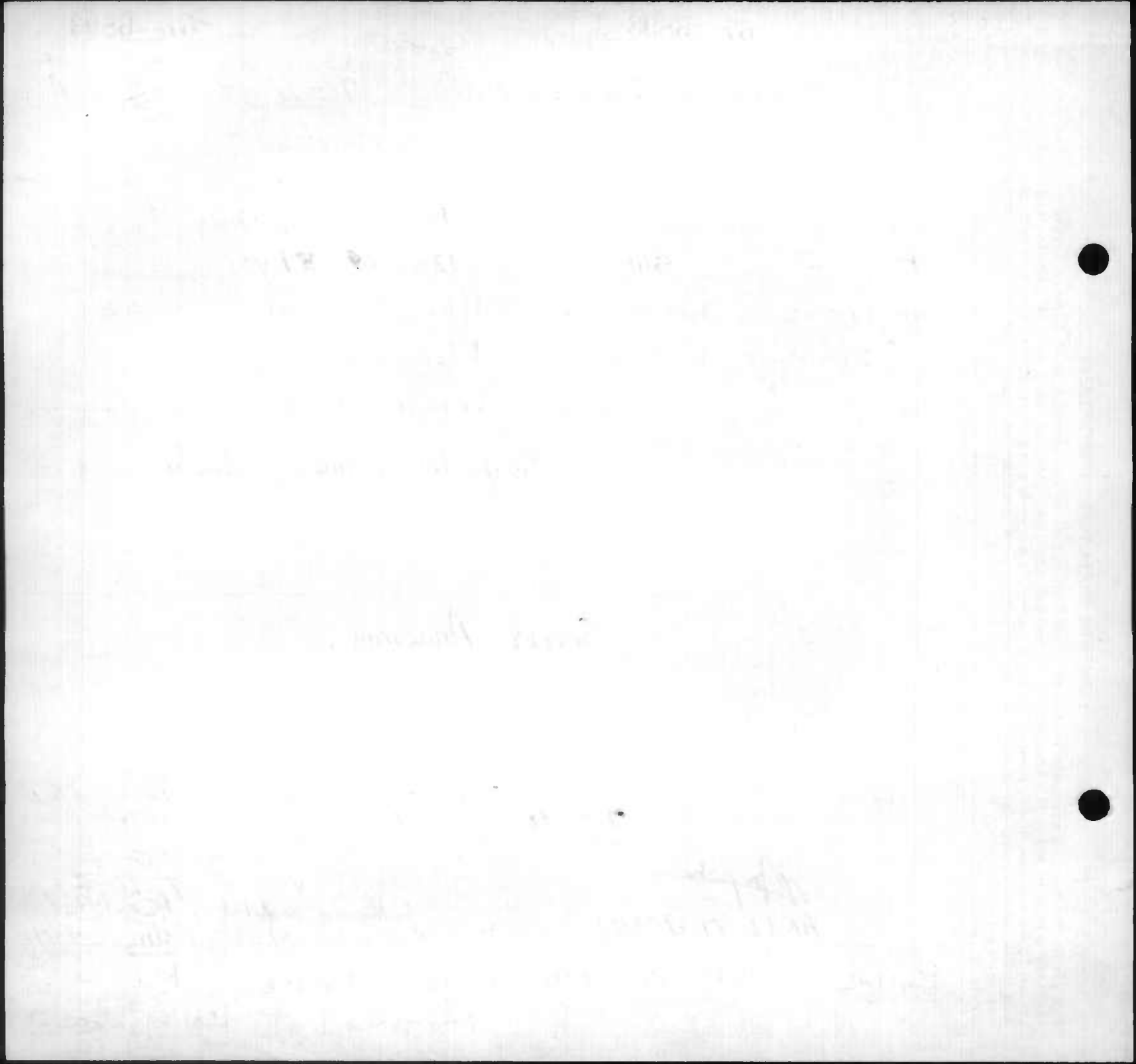
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6892	
BIRTH NO. South Carolina 67 6892		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Dondra Thomas		7-14-67 8:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, D. STREET ADDRESS (If rural, give location) 2733 Riggs Avenue			
5. SEX F.	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 5-12-1966	9. AGE (In years last birthday) 1	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY infant		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME NATHANIEL LOWERY		14. MOTHER'S MAIDEN NAME CLARETHA THOMAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Claretta Thomas - mother SAME	
18. 291X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pneumonitis DUE TO (B) Congestive heart failure secondary to pneumonia and heart failure DUE TO (C) Severe anemia, iron deficiency		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 14, 1967 to July 14, 1967 , that (I) (we) last saw the deceased alive on July 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A L Santos		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-15-67	
23C. PHYSICIAN'S NAME (Type) Dr. A L. Santos		23D. ADDRESS 1514 Division Street Provident Hospital, Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-18-67		24C. NAME OF CEMETERY or CREMATORY MOUNT AUBURN CEM.	
24D. LOCATION (City, town, or county) BALTIMORE,		(State) MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		25B. NAME OF REGISTRAR Robert E. Fairley, M.D.		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6893		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6893	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HOLLAND LILLIAN		2. DATE AND HOUR OF DEATH 7-16-67 9-15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland		D. STREET ADDRESS (If rural, give location) 1233 N. Gilman St.		16-02	
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Sing	8. DATE OF BIRTH 12-23-09	9. AGE (In years lost birthday) 57 yrs	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) Pikesville Md.	
13. FATHER'S NAME Osborne Holland		14. MOTHER'S MAIDEN NAME Florence Stepney		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNK		17. INFORMANT Ernest Holland	
18. 00211		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Suspected Pulmonary tuberculosis		9	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ DUE TO			
(C) _____ DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Severe Anaemia			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-13-1967 to 7-16-1967 , that (I) (we) last saw the deceased alive on 7-16-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anil M. Joshi				23B. DATE SIGNED 7-16-67	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI				23D. ADDRESS Lutheran Hospital of Maryland 730 Ashburton Street - Baltimore 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-20-67		24C. NAME OF CEMETERY OR CREMATORY MT. AUBURN	
24D. LOCATION BALTO, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		25B. NAME OF REGISTRAR Robert E. Fairburn	
25C. FUNERAL DIRECTOR MORTON + Dye		25D. ADDRESS 1701 LAURENS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6894	
BIRTH NO. 67 6894		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Smith H. Floride E.		2. DATE AND HOUR OF DEATH 15th July 1967. 11:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital		A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-02	
		D. STREET ADDRESS (If rural, give location) 100 N. Bentall St.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7-6-1914	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Thomas J. pearl		14. MOTHER'S MAIDEN NAME Mary E. Dixon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 240-585-733		17. INFORMANT Mrs. B. Westbrook	
18. 120X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Breast CA.		CAUSE OF DEATH (A) Breast CA. (B) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z) (AA) (AB) (AC) (AD) (AE) (AF) (AG) (AH) (AI) (AJ) (AK) (AL) (AM) (AN) (AO) (AP) (AQ) (AR) (AS) (AT) (AU) (AV) (AW) (AX) (AY) (AZ) (BA) (BB) (BC) (BD) (BE) (BF) (BG) (BH) (BI) (BJ) (BK) (BL) (BM) (BN) (BO) (BP) (BQ) (BR) (BS) (BT) (BU) (BV) (BW) (BX) (BY) (BZ) (CA) (CB) (CC) (CD) (CE) (CF) (CG) (CH) (CI) (CJ) (CK) (CL) (CM) (CN) (CO) (CP) (CQ) (CR) (CS) (CT) (CU) (CV) (CW) (CX) (CY) (CZ) (DA) (DB) (DC) (DD) (DE) (DF) (DG) (DH) (DI) (DJ) (DK) (DL) (DM) (DN) (DO) (DP) (DQ) (DR) (DS) (DT) (DU) (DV) (DW) (DX) (DY) (DZ) (EA) (EB) (EC) (ED) (EE) (EF) (EG) (EH) (EI) (EJ) (EK) (EL) (EM) (EN) (EO) (EP) (EQ) (ER) (ES) (ET) (EU) (EV) (EW) (EX) (EY) (EZ) (FA) (FB) (FC) (FD) (FE) (FF) (FG) (FH) (FI) (FJ) (FK) (FL) (FM) (FN) (FO) (FP) (FQ) (FR) (FS) (FT) (FU) (FV) (FW) (FX) (FY) (FZ) (GA) (GB) (GC) (GD) (GE) (GF) (GG) (GH) (GI) (GJ) (GK) (GL) (GM) (GN) (GO) (GP) (GQ) (GR) (GS) (GT) (GU) (GV) (GW) (GX) (GY) (GZ) (HA) (HB) (HC) (HD) (HE) (HF) (HG) (HH) (HI) (HJ) (HK) (HL) (HM) (HN) (HO) (HP) (HQ) (HR) (HS) (HT) (HU) (HV) (HW) (HX) (HY) (HZ) (IA) (IB) (IC) (ID) (IE) (IF) (IG) (IH) (II) (IJ) (IK) (IL) (IM) (IN) (IO) (IP) (IQ) (IR) (IS) (IT) (IU) (IV) (IW) (IX) (IY) (IZ) (JA) (JB) (JC) (JD) (JE) (JF) (JG) (JH) (JI) (JJ) (JK) (JL) (JM) (JN) (JO) (JP) (JQ) (JR) (JS) (JT) (JU) (JV) (JW) (JX) (JY) (JZ) (KA) (KB) (KC) (KD) (KE) (KF) (KG) (KH) (KI) (KJ) (KK) (KL) (KM) (KN) (KO) (KP) (KQ) (KR) (KS) (KT) (KU) (KV) (KW) (KX) (KY) (KZ) (LA) (LB) (LC) (LD) (LE) (LF) (LG) (LH) (LI) (LJ) (LK) (LL) (LM) (LN) (LO) (LP) (LQ) (LR) (LS) (LT) (LU) (LV) (LW) (LX) (LY) (LZ) (MA) (MB) (MC) (MD) (ME) (MF) (MG) (MH) (MI) (MJ) (MK) (ML) (MN) (MO) (MP) (MQ) (MR) (MS) (MT) (MU) (MV) (MW) (MX) (MY) (MZ) (NA) (NB) (NC) (ND) (NE) (NF) (NG) (NH) (NI) (NJ) (NK) (NL) (NM) (NN) (NO) (NP) (NQ) (NR) (NS) (NT) (NU) (NV) (NW) (NX) (NY) (NZ) (OA) (OB) (OC) (OD) (OE) (OF) (OG) (OH) (OI) (OJ) (OK) (OL) (OM) (ON) (OO) (OP) (OQ) (OR) (OS) (OT) (OU) (OV) (OW) (OX) (OY) (OZ) (PA) (PB) (PC) (PD) (PE) (PF) (PG) (PH) (PI) (PJ) (PK) (PL) (PM) (PN) (PO) (PP) (PQ) (PR) (PS) (PT) (PU) (PV) (PW) (PX) (PY) (PZ) (QA) (QB) (QC) (QD) (QE) (QF) (QG) (QH) (QI) (QJ) (QK) (QL) (QM) (QN) (QO) (QP) (QQ) (QR) (QS) (QT) (QU) (QV) (QW) (QX) (QY) (QZ) (RA) (RB) (RC) (RD) (RE) (RF) (RG) (RH) (RI) (RJ) (RK) (RL) (RM) (RN) (RO) (RP) (RQ) (RR) (RS) (RT) (RU) (RV) (RW) (RX) (RY) (RZ) (SA) (SB) (SC) (SD) (SE) (SF) (SG) (SH) (SI) (SJ) (SK) (SL) (SM) (SN) (SO) (SP) (SQ) (SR) (SS) (ST) (SU) (SV) (SW) (SX) (SY) (SZ) (TA) (TB) (TC) (TD) (TE) (TF) (TG) (TH) (TI) (TJ) (TK) (TL) (TM) (TN) (TO) (TP) (TQ) (TR) (TS) (TT) (TU) (TV) (TW) (TX) (TY) (TZ) (UA) (UB) (UC) (UD) (UE) (UF) (UG) (UH) (UI) (UJ) (UK) (UL) (UM) (UN) (UO) (UP) (UQ) (UR) (US) (UT) (UU) (UV) (UW) (UX) (UY) (UZ) (VA) (VB) (VC) (VD) (VE) (VF) (VG) (VH) (VI) (VJ) (VK) (VL) (VM) (VN) (VO) (VP) (VQ) (VR) (VS) (VT) (VU) (VV) (VW) (VX) (VY) (VZ) (WA) (WB) (WC) (WD) (WE) (WF) (WG) (WH) (WI) (WJ) (WK) (WL) (WM) (WN) (WO) (WP) (WQ) (WR) (WS) (WT) (WU) (WV) (WW) (WX) (WY) (WZ) (XA) (XB) (XC) (XD) (XE) (XF) (XG) (XH) (XI) (XJ) (XK) (XL) (XM) (XN) (XO) (XP) (XQ) (XR) (XS) (XT) (XU) (XV) (XW) (XX) (XY) (XZ) (YA) (YB) (YC) (YD) (YE) (YF) (YG) (YH) (YI) (YJ) (YK) (YL) (YM) (YN) (YO) (YP) (YQ) (YR) (YS) (YT) (YU) (YV) (YW) (YX) (YY) (YZ) (ZA) (ZB) (ZC) (ZD) (ZE) (ZF) (ZG) (ZH) (ZI) (ZJ) (ZK) (ZL) (ZM) (ZN) (ZO) (ZP) (ZQ) (ZR) (ZS) (ZT) (ZU) (ZV) (ZW) (ZX) (ZY) (ZZ)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 8 1967 to July 15 1967 , that (I) (we) last saw the deceased alive on July 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Byung Kap Kang		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 15, 1967	
23C. PHYSICIAN'S NAME (Type) BYUNG KAP KANG		M.D. 23D. ADDRESS Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-23-67		24C. NAME OF CEMETERY or CREMATORY Silver Mount Cemetery	
24D. LOCATION (City, town, or county) (State) Charlotte N.C.		25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Morton + Dyett		ADDRESS 1701 Laurens			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 6895		67 6895	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) KERR, EDWARD W.			2. DATE AND HOUR OF DEATH July 15, 1967 4:00 a. m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL			MARYLAND BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) CHASE D. STREET ADDRESS (If rural, give location) EBENEZER ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-25-13	9. AGE (In years last birthday) 54	10. Under 1 Yr. Months; Days 11. Under 24 Hrs. Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurseryman		10B. KIND OF BUSINESS OR INDUSTRY Ladnscape Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME LEE KERR		
14. MOTHER'S MAIDEN NAME MINNIE ELY			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214 01 3175			17. INFORMANT Ada E. Kerr Ebenezer Road, Chase, Md. 21027		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 6 mos.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. POLYMYOSITIS			6 mos.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 17, 1966 to July 15, 1967, that (I) (we) lost saw the deceased alive on July 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Joseph Shaw			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/15/67
23C. PHYSICIAN'S NAME (Type) David Joseph Shaw			23D. ADDRESS Johns Hopkins Hospital, Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 19, 1967		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Jesus Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR R. E. Shaw		ADDRESS 1211 Chesaco Avenue	

Handwritten signature or name, possibly "James J. [unclear]".

67. 6896

BALTIMORE CITY HEALTH DEPARTMENT

67. 6896

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Althea Carter MC INTYRE

2. DATE AND HOUR PRONOUNCED DEAD

July 16, 1967 7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2313 Pennsylvania Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

4-10-1913

9. AGE (in years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Cheatham

14. MOTHER'S MAIDEN NAME

Nora Cheatham

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-32-2130

17. INFORMANT

ADDRESS

Mrs. Althea O'Bannon, 1811 Etting St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Alteration of Liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Hemoperitoneum due to Laceration of Liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unknown

21D. TIME
OF INJURY
(APPROX.)

Unknown

21E. INJURY OCCURRED

m. WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

apparently fell on right flank

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-21-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law, 802 Madison Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 6897 CERTIFICATE OF DEATH					Registered No. 67 6897					
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					Simpson EDNA A DEC			7-14-67, 7 ⁰⁰ M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY					
UNIVERSITY OF MD. Hosp. & Inf.					MARYLAND					
38					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					Baltimore					
					D. STREET ADDRESS (If rural, give location)					
					907 FAYETTE ST.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		
♀	NEGRO	married		3/3/38	29	hse. wife		Maryland		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
						Maryland		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Joseph Jones					Katie Leipold					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
						Ruth Lopp 1122 Kevin Rd. Baltimore				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO					
ANTECEDENT CAUSES					CARDIAC & Respiratory Arrest					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO					
					Pulmonary Fibrillation					
					(C) DUE TO					
					Pneumonia					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
2				Yes						
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?						
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (I) (this hospital) attended the deceased from 7-13 1967 to 7-14 1967, that (I) (we) lost saw the deceased alive on 7-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE					23B. DATE SIGNED					
E. A. Sander					7-14-67					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
Miguel H. Gonzalez					University of Md. Hospital Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)				
Burial		7/19/67		Mt. Calvary Cemetery		A A County MD				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS				
		Robert G. Johnson		Adolphus Halstead 1206 W North Ave						

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **67 6898**

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
 (Type or Print)

Eva Finley (Lewis)

2. DATE AND HOUR OF DEATH

7-17-67

3:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

Provident Hospital, Inc.

1514 Division Street

Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
 A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore,

D. STREET ADDRESS (If rural, give location)

1657 W. North Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
 WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

5-15-07

9. AGE (In years last birthday)

60 yrs.

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Lewis Oliver - Friend

SAME

18. **434.11**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Heart Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **July 12, 1967** to **July 17, 1967**, that (I) (we) last saw the deceased alive on **July 17, 1967** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. C. Laredo

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7-18-67

23C. PHYSICIAN'S NAME (Type)

Dr. C. Laredo

M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/21/67

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION

Baltimore Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 19 1967 Robert E. Farkas, M.D.

Adolphus Halstead 1206 W North Ave

100-100000

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 67 6899					CERTIFICATE OF DEATH						
M.E. CASE NO.					Registered No. 67 6899						
1. NAME OF DECEASED (Type or Print) <u>BROOKS, WILBERT, L.</u>					2. DATE AND HOUR OF DEATH <u>7.16.67. 8:30 P.M.</u>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <u>LUTHERAN HOSPITAL OF MARYLAND</u> <u>46</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>GLEN BURNIE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>6206 FLAMINGO DR.</u>						
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11.1.01</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Louison Brooks</u>					14. MOTHER'S MAIDEN NAME <u>Littie Holmes</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>James Brooks</u>			ADDRESS <u>same</u>			
18. <u>32715-1810</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <u>RESPIRATORY ARREST</u> DUE TO (B) <u>PULMONARY EMPHYSEMA +</u> DUE TO <u>FIBROSIS</u> <u>Malnutrition due to CA Bladder</u>					INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19A. DATE OF OPERATION <u>7.5.67</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA. Bladder</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?						
22. I certify that (this hospital) attended the deceased from <u>6.13</u> 19 <u>67</u> to <u>7.16</u> 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>7.16.67</u> 19 <u>67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.											
23A. SIGNATURE <u>S. Sherreen</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>7.16.67.</u>			
23C. PHYSICIAN'S NAME (Type) <u>SHEIKH, SHEREEN.</u>					23D. ADDRESS M.D. <u>Lutheran Hospital</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>7-21-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>mt Calvary Cmt</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 19 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Farley</u>			25C. FUNERAL DIRECTOR <u>Shoy Wilson 1000 Broadway Ave</u>			ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6900	
BIRTH NO. 67 6900				CERTIFICATE OF DEATH	
M.E. CASE NO.				DATE AND HOUR OF DEATH 7/18/67 M. 5	
1. NAME OF DECEASED (Type or Print) JEFFERSON LIVINGSTON				2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 704	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNA HOPKINS HOSPITAL 33				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 1012 NORTH WASHINGTON STREET	
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-14-08	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Worker School		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME EDWARD JEFFERSON		14. MOTHER'S MAIDEN NAME MAMIE HODGES		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Korpella Livingston Lince	
18. 162.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHIOCARCINOMA OF THE LUNG		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>July 17</u> 19 <u>67</u> to <u>July 18</u> 19 <u>67</u> , that <u>(H)</u> (we) lost saw the deceased alive on <u>July 16</u> 19 <u>67</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.		21F. HOW DID INJURY OCCUR?			
23A. SIGNATURE John T. Flaherty				23B. DATE SIGNED 7-18-67	
23C. PHYSICIAN'S NAME (Type) JOHN T. FLAHERTY				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-22-67		24C. NAME of CEMETERY or CREMATORY Adventist Cent	
24D. LOCATION (City, town, or county) Baltimore		24E. NAME of REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR Chapman Brown Brantley	
25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6901		CERTIFICATE OF DEATH		67 6901	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) RUHWADEL, ETHEL E.			7/18/67 " 7.15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL 46			A. STATE Md B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 3101 NORMOUNT AVE.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 4/7/00	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Ruhwadel			14. MOTHER'S MAIDEN NAME Laura V. Thomas		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS Balt. Md. 21216 Roland G. Ruhwadel 3101 Normount Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CHRONIC LARGE BOWEL OBSTRUCTION 7 WEEKS CARCINOMA OF RECTUM			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/16/67 19 7/18 to 7/18 19 67 , that (I) (we) last saw the deceased alive on 7/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. Queral M.D.				23B. DATE SIGNED 7/18/67	
23C. PHYSICIAN'S NAME (Type) FERNANDO QUERAL				23D. ADDRESS M.D. LUTHERAN HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/22/67		24C. NAME of CEMETERY or CREMATORY Woodlawn	
				24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Baltimore, Md. 21202 Wm. Cook-Brooks Inc. 1217 St. Paul St.	

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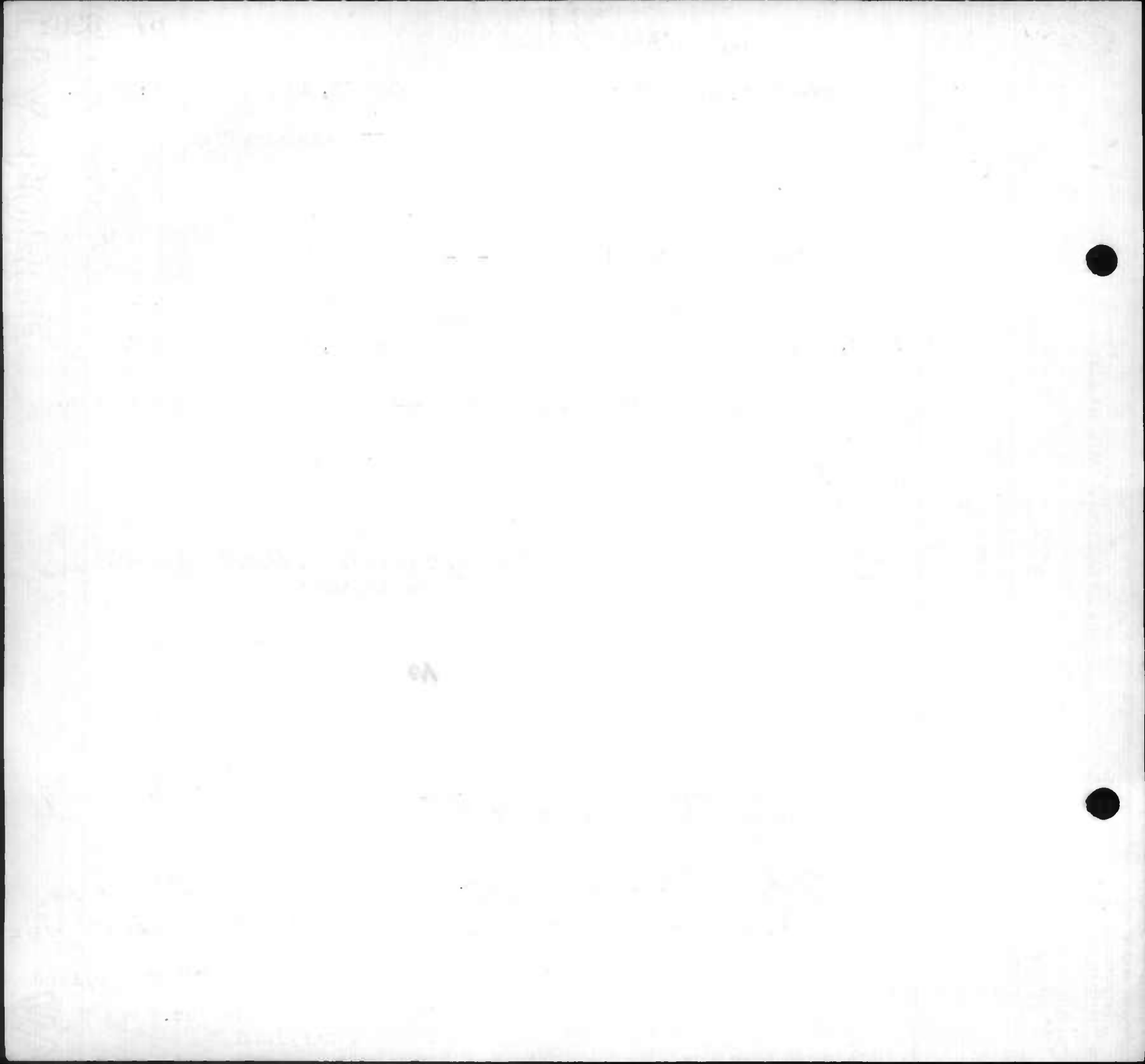
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6902 CERTIFICATE OF DEATH					Registered No. 67 6902				
BIRTH NO. 67 6902					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Rosenberger May Etta					2. DATE AND HOUR OF DEATH July 17, 1967 7:10 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BOLTON HILL CONV. & NURSING CENTER					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1832 E. 29th St.				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-30-1885	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Delaware, Wilmington		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Wilkinson, George					14. MOTHER'S MAIDEN NAME Clara, Anna Tazewell				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 217 01 6145		17. INFORMANT ADDRESS BOLTON HILL NURSING CENTER 1400 John St.				
18. 443X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Hypertensive CV disease DUE TO (B) Anterior chain generalized DUE TO (C) Thrombotic embolism over extension					INTERVAL BETWEEN ONSET AND DEATH years years weeks				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 7/17/67 to 7/17/67 that (I) (we) last saw the deceased alive on 7/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE ALLAN H. MACHT M.D.					23B. DATE SIGNED 7/17/67		23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/20/67		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn XXXXXXXX Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUL 19 1967			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Henry Sander & Sons Inc. Baltimore Maryland				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6903

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 6903

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Helen

Stevenson

2. DATE AND HOUR OF DEATH

7-16-67

11: A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

00

1223 N. Gay St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1223 N. Gay St.

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

Female Colored

Married

9-25-1893

73

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Housewife

own home

Baltimore, Md

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Edward Gross

Caroline Foreman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

No

None

George F. Stevenson 1223 N. Gay St

442 X1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Chronic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

6 wks

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *2-10-* *1967* to *7-14-* *1967*, that (I) (we) last saw the deceased alive on *7-14-* *1967* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE

Wm. L. Berry

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

7-18-67

23C. PHYSICIAN'S NAME (Type)

Wm. L. BERRY

M.D.

23D. ADDRESS

1237 N. Caroline H.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7-19-67

National Cemetery

5501 Frederick Ave Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

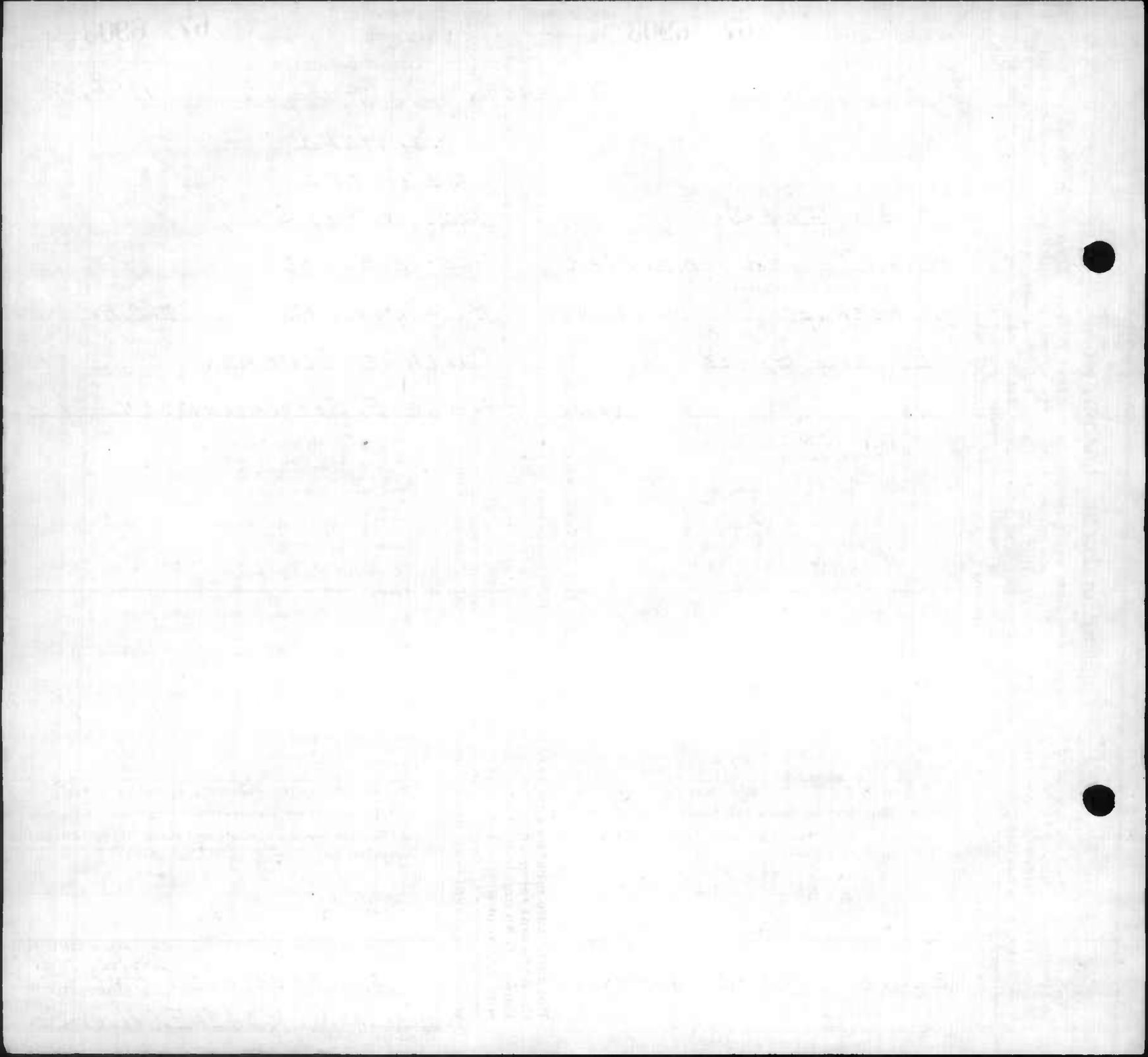
25C. FUNERAL DIRECTOR

ADDRESS

JUL 19 1967

Phub E. Taylor

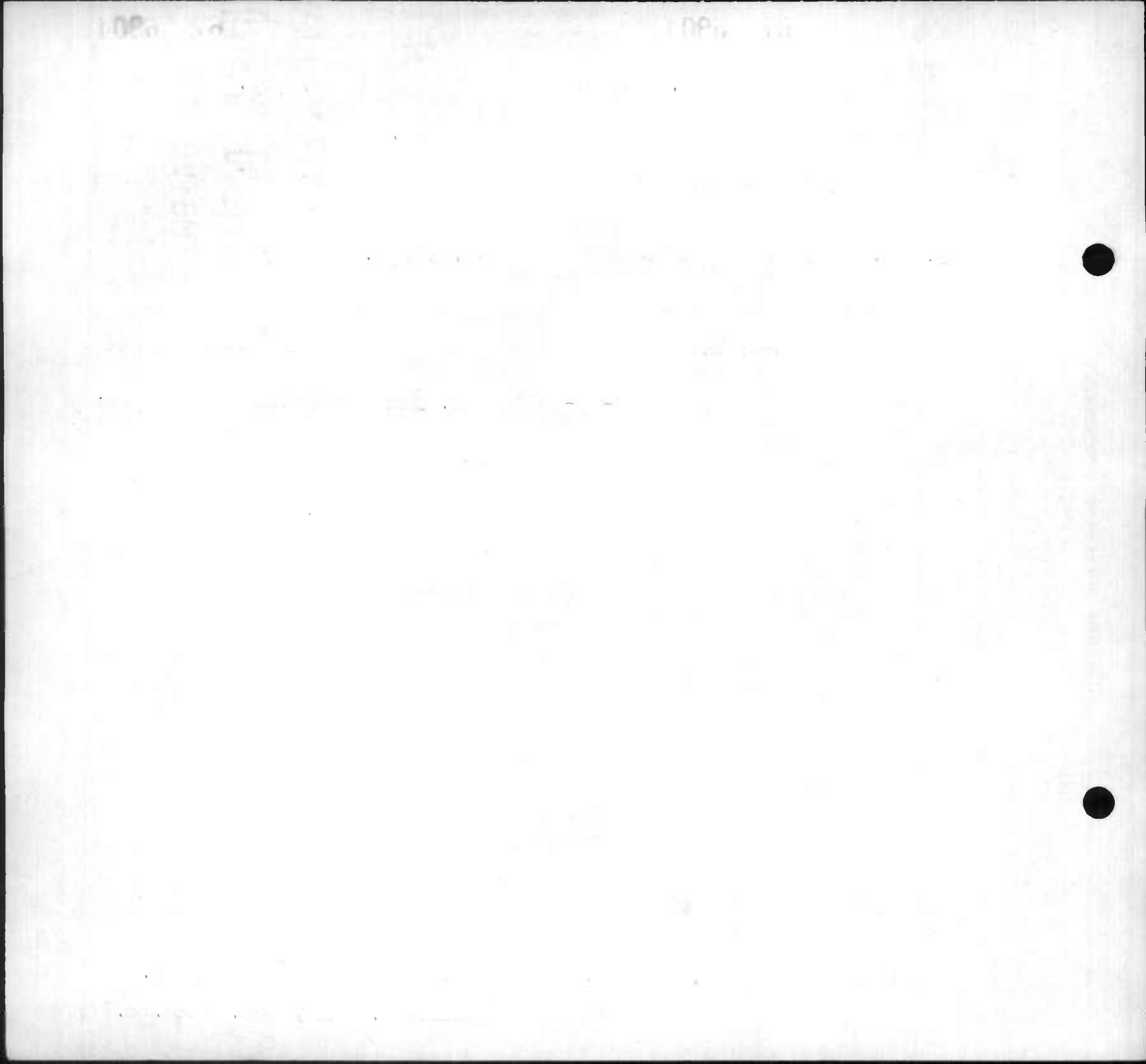
Randolph Collick 2431 E. Oliver St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

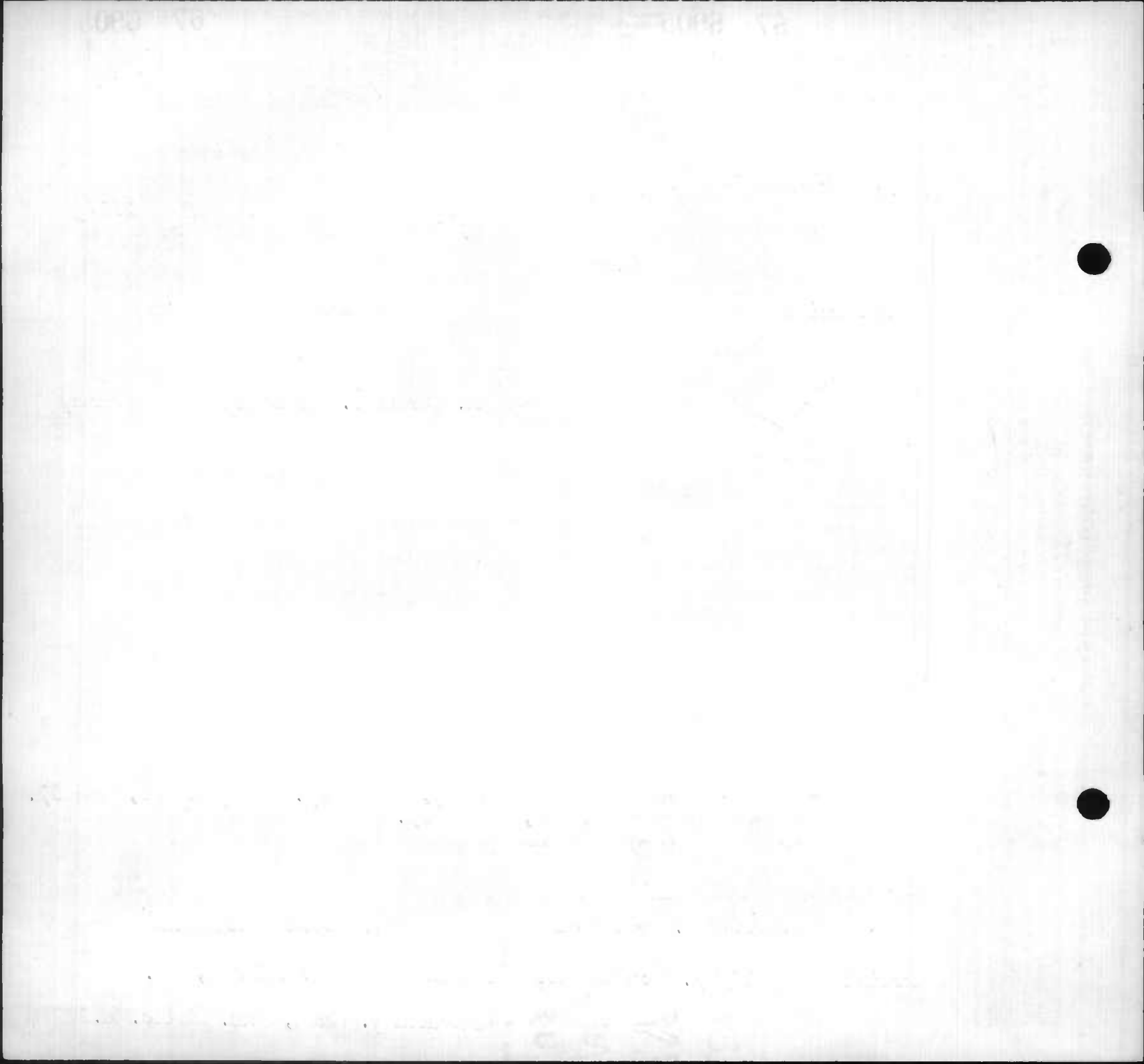
BIRTH NO. 67 6904		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6904	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Myrtle L. Reagan		2. DATE AND HOUR OF DEATH July 16, 1967. 1 230 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214	
FULL NAME OF HOSPITAL OR INSTITUTION 00 5006 Morello Road		D. STREET ADDRESS (If rural, give location) 5006 Morello Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH Dec. 4, 1892.	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Levin Hurley		14. MOTHER'S MAIDEN NAME Octavia Langrall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-7071		17. INFORMANT Mrs. Frances Heintz	
18. 332 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral thrombosis DUE TO (B) Arteriosclerosis, generalized 3 years - DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 18 mos -		19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from September 19 47 to July 16 1947, that (I) (we) last saw the deceased alive on July 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE James R. Karns M.D.		23B. DATE SIGNED July 16, 1967		23C. PHYSICIAN'S NAME (Type) JAMES R. KARNs M.D.	
23D. ADDRESS 800 CATHEDRAL ST. BALTIMORE MD		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/19/67	
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md.		25D. ADDRESS 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6905	
BIRTH NO. 67 6905				CERTIFICATE OF DEATH	
M.E. CASE NO. 08-03-40					
1. NAME OF DECEASED (Type or Print) Wheatley, Carrie		2. DATE AND HOUR OF DEATH 7-16-67 8 50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE CITY 2603 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MARYLAND D. STREET ADDRESS (If rural, give location) 3333 RAMONA AVE. 21213			
5. SEX F	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 10-29-84	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HENRY FAUL		14. MOTHER'S MAIDEN NAME ANNA GRIMMEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-52-2462		17. INFORMANT ADDRESS Mr. James T. Wheatley (Same)	
18. 450.01		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Pneumonia DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic Vascular disease DUE TO			
		(C) Hypoplastic Anemia			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NONE	
22. I certify that (H) (this hospital) attended the deceased from June 9, 1967 to July 16, 1967 , that (H) (we) last saw the deceased alive on July 16, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael S. Weinstock				23B. DATE SIGNED 7-16-67	
23C. PHYSICIAN'S NAME (Type) Michael S. Weinstock M.D.				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/21/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="float: left; font-size: 2em; margin-right: 10px;">P-3601</div> <div style="text-align: center;"> 67 6906 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="clear: both;"></div>		CERTIFICATE OF DEATH		Registered No. 67 6906	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) EMERSON W. POTTER, SR.		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> July 17, 1967 7 P.M. </div>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 5072 E. Federal St.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 26-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5072 E. Federal St.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Nov. 27, 1891	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Business- ret'd		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nelson Potter		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 215-28-8662		17. INFORMANT Mrs. Elsie W. Potter	
ADDRESS (Same)					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I		CAUSE OF DEATH (A) DUE TO Acute Coronary Occlusion (B) DUE TO Atherosclerosis of Heart & Coronaries (C)		INTERVAL BETWEEN ONSET AND DEATH sudden	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/29/67 to 7/17/67 , that (I) (we) last saw the deceased alive on 7/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Vatana Sadarananda M.D.				23B. DATE SIGNED 7/18/67	
23C. PHYSICIAN'S NAME (Type) Dr. Vatana Sadarananda				23D. ADDRESS 6801 Belair Road, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/20/67		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.--Balto., Md....14	

1871

John Henry
Harrison

1871

John Henry

67 6907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 6907

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

BRADLEY, WILSON E. Sr.

2. DATE AND HOUR OF DEATH

18 JULY 1967 1²⁰ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)4940 Eastern Avenue
Baltimore, Maryland 21224

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
MarylandB. COUNTY
27-44

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5404 Carter Avenue 21214

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

1-28-94

9. AGE (In years
last birthday)

73

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Chief Tarriff

10B. KIND OF BUSINESS OR INDUSTRY

Bureau B&ORR

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Wilson Bradley

14. MOTHER'S MAIDEN NAME

Julia Kraft

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes WW 1

16. SOCIAL
SECURITY NO.

705-05-5403

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18.

420.11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, assthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A)

MYOCARDIAL INFARCTION 26 da.

(B)

DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

CHRONIC RENAL DISEASE

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 22 JUNE 19 67 to 18 JULY 19 67.
that (I) (we) last saw the deceased alive on 18 JULY 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Melvyn S. Tockman

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

18 JULY 1967

23C. PHYSICIAN'S
NAME (Type)

Melvyn Tockman

M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/21/67.

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 20 1967

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

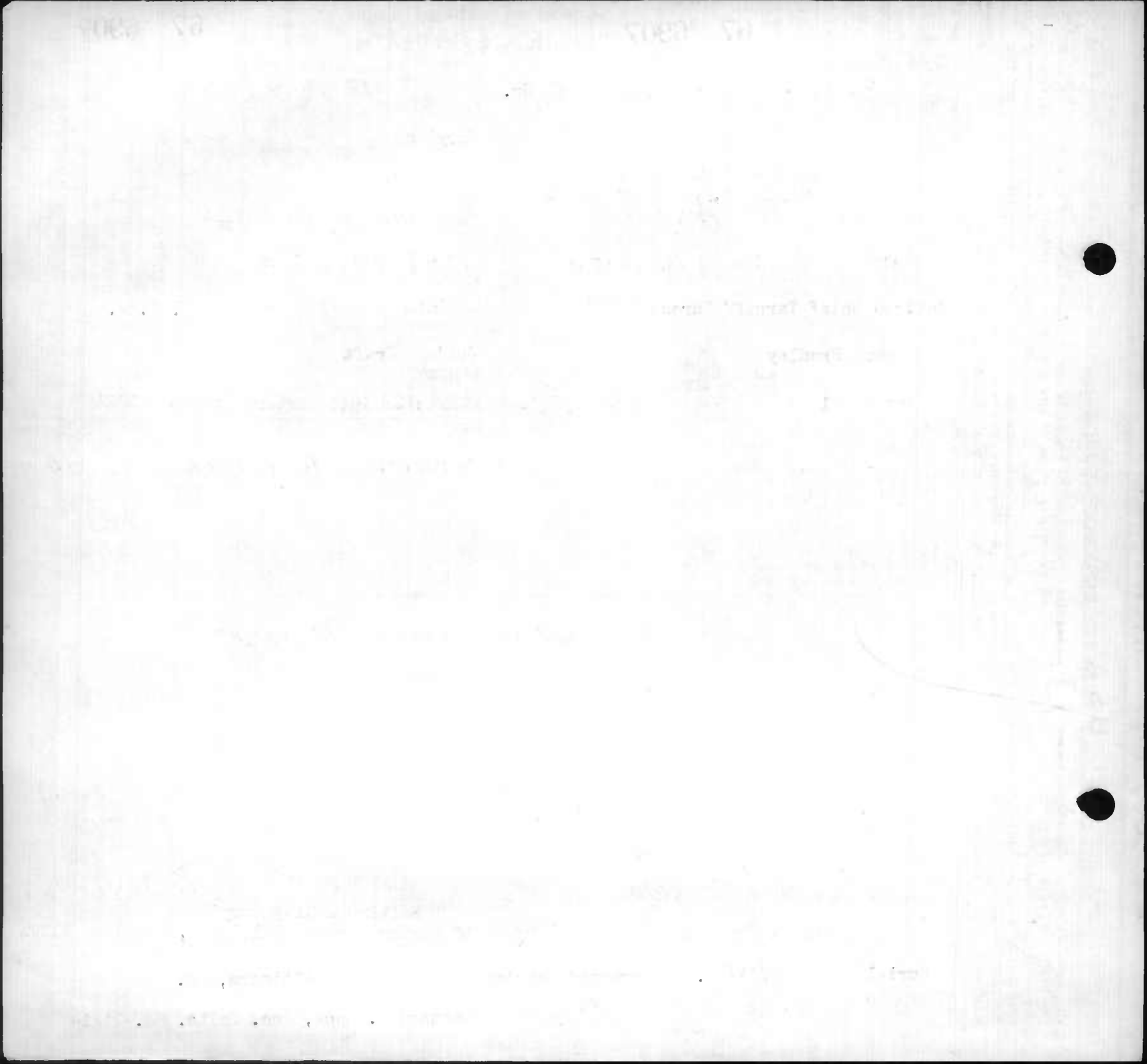
25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



67 6908

BALTIMORE CITY HEALTH DEPARTMENT

67 6908

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

NATALIE MARY BOYCE

2. DATE AND HOUR PRONOUNCED DEAD

July 13, 1967 10:41 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Montgomery Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Chevy Chase 65-20

D. STREET ADDRESS (If rural, give location)

8304 Kerry Road, Chevy Chase Md.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug. 7, 1912

9. AGE (In years
last birthday)

54

10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lawrence, Mass.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Thomas J. Condon

14. MOTHER'S MAIDEN NAME

Mary Harkness

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-34-3323

17. INFORMANT Sister 9701 Fields Road

Kathryn Lawlor Shook- Gaithersburg, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-17-67

23C. NAME OF CEMETERY or CREMATORY

Gate of Heaven Cemetery Silver Spring, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 20 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Robert A. Pumphrey - Bethesda, Md.

WALLACE P. GORDON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

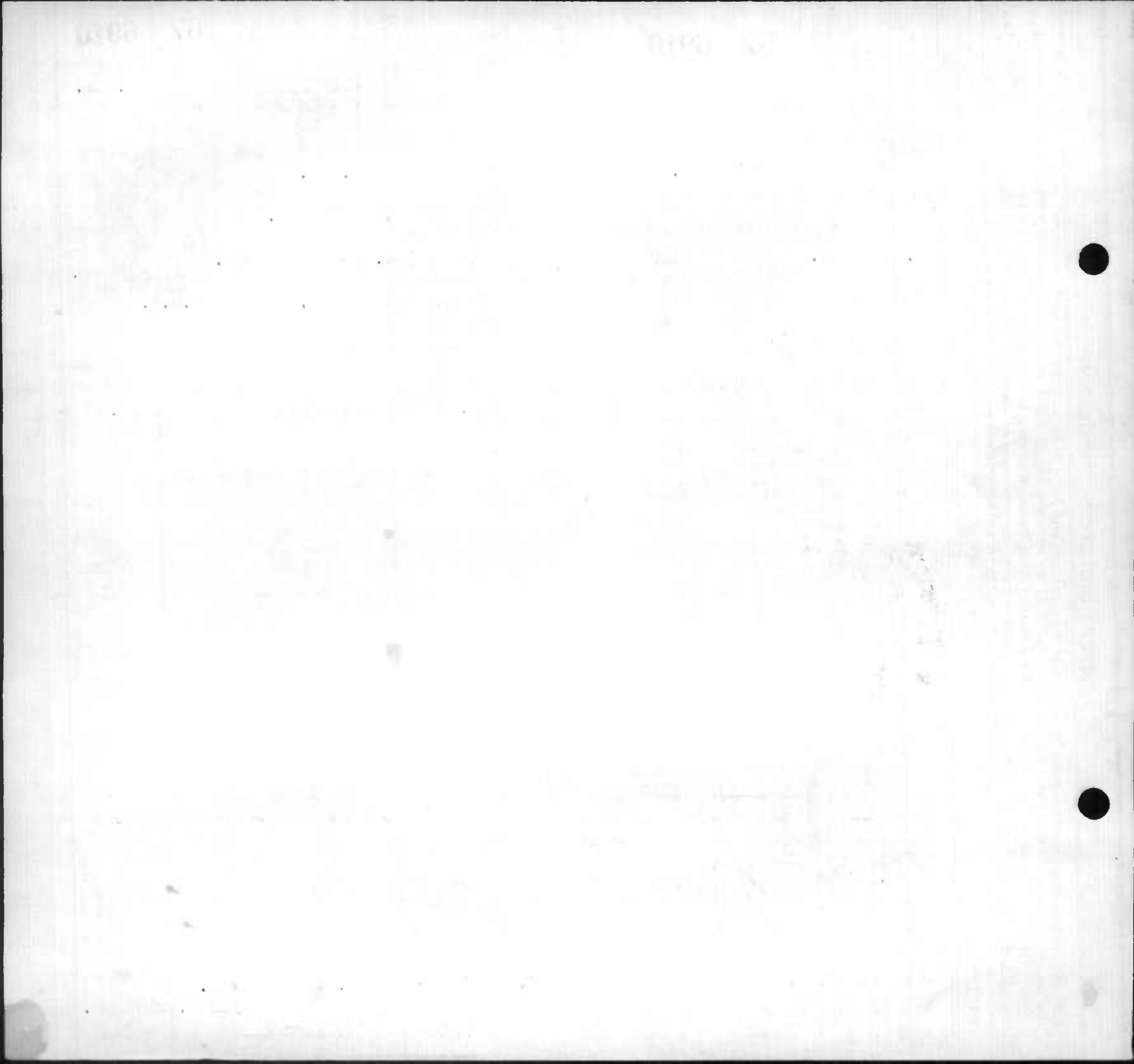
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6909	
BIRTH NO. 67 6909		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 16 July 1967 7:35 P	
1. NAME OF DECEASED (Type or Print) Martin, Charles W.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Allegany Co.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Cumberland D. STREET ADDRESS (If rural, give location) 11 Hampton Place	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 25 April 1898
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Brewery Worker		11. BIRTHPLACE (State or foreign country) Maryland	9. AGE (In years last birthday) 69
13. FATHER'S NAME Martin, James Conrad		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-4947	17. INFORMANT Margaret Smith
18. 199.2/1		ADDRESS 331 Dorn Avenue Cumberland, Maryland	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) RECURRENT CARCINOMA OF LARYNX, PHARYNX (B) _____ (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 3-5 MONTHS	
19A. DATE OF OPERATION MAY 26, 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA RECURRENT	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from MAY 25 19 67 to July 16 19 67 , that (I) (we) last saw the deceased alive on July 16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Marion L. Talbot		23B. DATE SIGNED July 16, 1967	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS M.D. UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/19/67	
24C. NAME OF CEMETERY or CREMATORY Sunset Memorial Park		24D. LOCATION (City, town, or county) (State) Cumberland Allegany Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Talbot	
25C. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland, Maryland 21502	

Environ —

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6910		CERTIFICATE OF DEATH		67 6910	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ROSA GIORDANO			JULY 15 1967 I.O.O.A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
400 CORNWALL ST.			2605		
00			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTO. Md.		
			D. STREET ADDRESS (If rural, give location)		
			400 CORNWALL ST.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F.	W.	WIDOWED, DIVORCED (specify)	MARCH 3rd. 1880	87 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE			VALUARNERA ITALY.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
CARMELO FUNARI			ANTONINA MAENZA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO			NONE		GIORDANO BARBER SHOP EAST POINT
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
443 XI			Hypertension Cardiac -		
ANTECEDENT CAUSES			(A) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 19 53 to 7/15 19 67, that (I) (we) last saw the deceased alive on 6/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph R. Liberto M.D.				7/17/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOSEPH R. LIBERTO M.D.				3508 Buck St. Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
JULY 18 1967		BURIAL		LORRAINE PARK. WINDSOR MILL RD. WOODLAWN Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 20 1967		Robert E. Farber, M.D.		Frank Della Torre 322 S. HIGH ST.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6911

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

J.

SIMPSON

2. DATE AND HOUR PRONOUNCED DEAD

July 14, 1967

11:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Prince Georges

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Apt. 511 - 610 Main Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

2-8-1947

9. AGE (In years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

ELECTRICIAN

11. BIRTHPLACE (State or foreign country)

WILMINGTON, DEL

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

CHARLES J. SIMPSON, SR.

14. MOTHER'S MAIDEN NAME

JEWELL WALKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

44-76-8422

17. INFORMANT

JEWELL W. SIMPSON MINQUEDALE, DEL

ADDRESS 19 NEWPORT AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cranio-cerebral Injury

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

U.S. Route 1 - 3 mi. S. of Savage

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
July 14, 1967 10:45

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Vehicle left road
and hit telephone pole

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/15/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-18-67

23C. NAME of CEMETERY or CREMATORY

CHERRY HILL METH.

23D. LOCATION

(City, town, or county)

(State)

CHERRY HILL CECIL MD.

24A. DATE REC'D BY HEALTH DEPT.

JUL 20 1967

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Pippin Funeral Home

24D. ADDRESS

ELKTON, MD.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6912	
BIRTH NO. 67 6912				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH JULY 15, 1967 12⁰⁵ P.M.	
1. NAME OF DECEASED (Type or Print) REILLY, ANNA MAE					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL				A. STATE MARYLAND	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 2081 WOODBOURNE AVENUE	
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-19-24	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
13. FATHER'S NAME GRAHAM				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 141-14-4921	
17. INFORMANT MRS. CHARLES MAISCH,				ADDRESS BALTO. MO.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) HEPATOMA OF LIVER				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) myocardial infarction & mural thrombosis of left ventricle	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				INTERVAL BETWEEN ONSET AND DEATH W.K.A.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-2 19 67 to 7-15 19 67 , that (I) (we) last saw the deceased alive on 7-15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raul V. Desquitado				23B. DATE SIGNED 7-15-67	
23C. PHYSICIAN'S NAME (Type) RAUL DESQUITADO				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/18/1967		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	

BY AIR

REPLY BY AIR

MARYLAND
BALTIMORE
3021 WOODBONE AVENUE

UNION MEMORIAL HOSPITAL

8-18-54 45

F WHITE Widowed

N.Y.C.

NEW JERSEY

WAITRESS

UNKNOWN

GRAHAM

NO

Hospital of Liver

Reported information
from the
of left side

7-11-54

67

7-2

7-12

James H. [Signature]

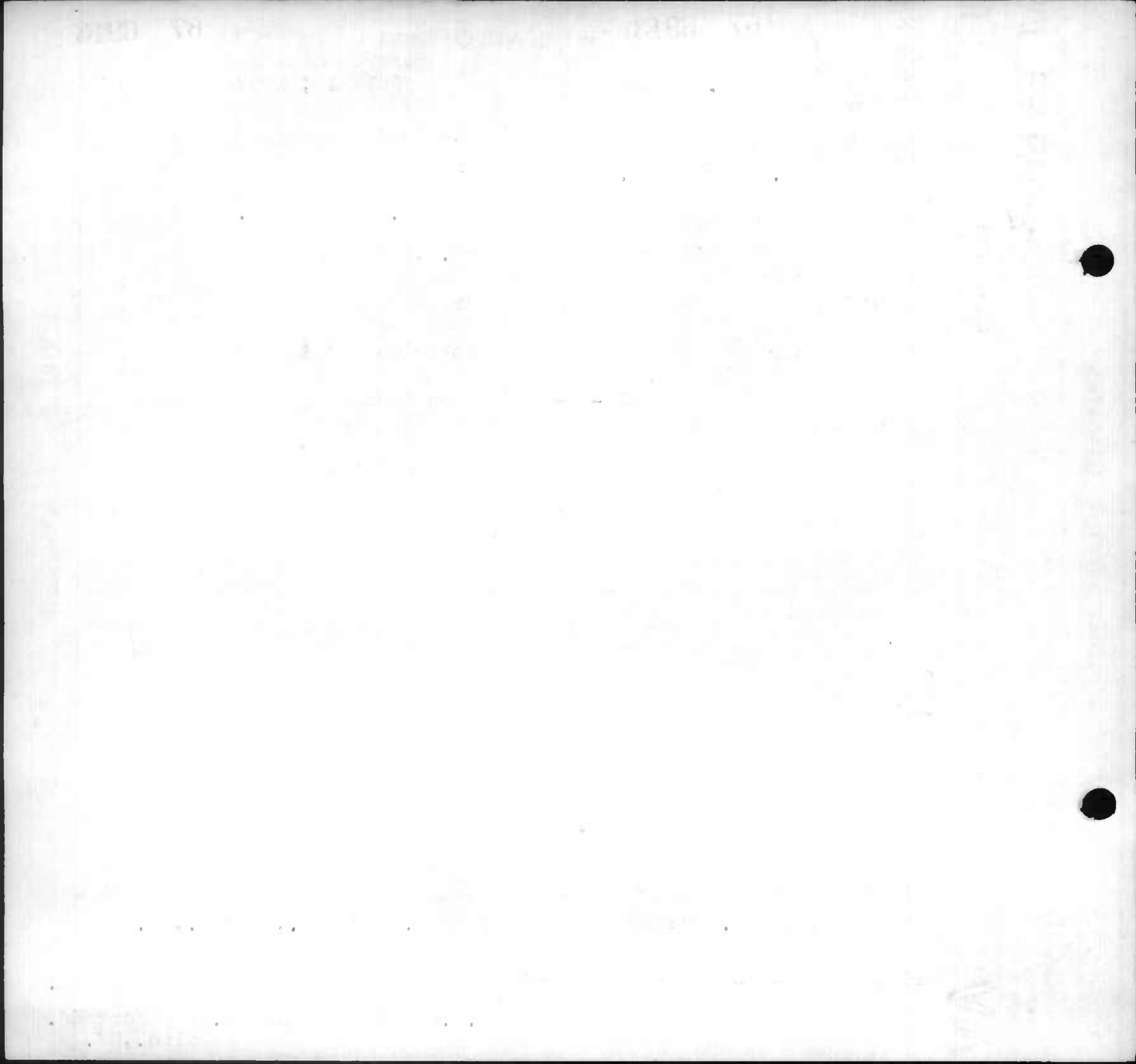
RAUL PESQUERA

UNION MEMORIAL HOSPITAL

7-12-54

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6913	
BIRTH NO. 67 6913		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary M. Cooney		July 16, 1967 1 ⁰⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3908 N. Charles St.			Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3908 N. Charles St.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct. 9, 1877	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Gunther			14. MOTHER'S MAIDEN NAME Catharine Schlienger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-46-1915	17. INFORMANT Agnes Cooney		ADDRESS Above
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 332X4260X			CAUSE OF DEATH (A) DUE TO Cerebral thrombosis (B) DUE TO Gen. Arteriosclerosis (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 week 15 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Diabetes Mellitus		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 19 55 to July 16, 19 67 , that (I) (we) last saw the deceased alive on July 15, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wm. H. Grenzer				23B. DATE SIGNED 7.18.67.	
23C. PHYSICIAN'S NAME (Type) William H. Grenzer				23D. ADDRESS 1520 E. 33rd St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-19-67		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			
25D. ADDRESS 4905 York Rd. Balto., Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6914		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6914	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) ANNA M. CHAMBERS			7/19/67 12:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3404 St. Paul St.			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3404 St. Paul St.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-28-1876	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John Vollman			14. MOTHER'S MAIDEN NAME Anna M. Rodeman		12. CITIZEN OF WHAT COUNTRY? USA
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-03-9870		17. INFORMANT J. H. LeRoy Chambers
					ADDRESS Balto., Md.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <i>metastatic carcinoma</i> (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-17 1967 to 7-19 1967, that (I) (we) last saw the deceased alive on 7-17-67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Francis X. Carmody</i>				23B. DATE SIGNED 7-19-67	
23C. PHYSICIAN'S NAME (Type) Francis X. Carmody				23D. ADDRESS 3201 N. Charles St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-20-67		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
				24D. LOCATION (City, town, or county) (State) Pikesville Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	

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Handwritten text, possibly a signature or name, oriented vertically.

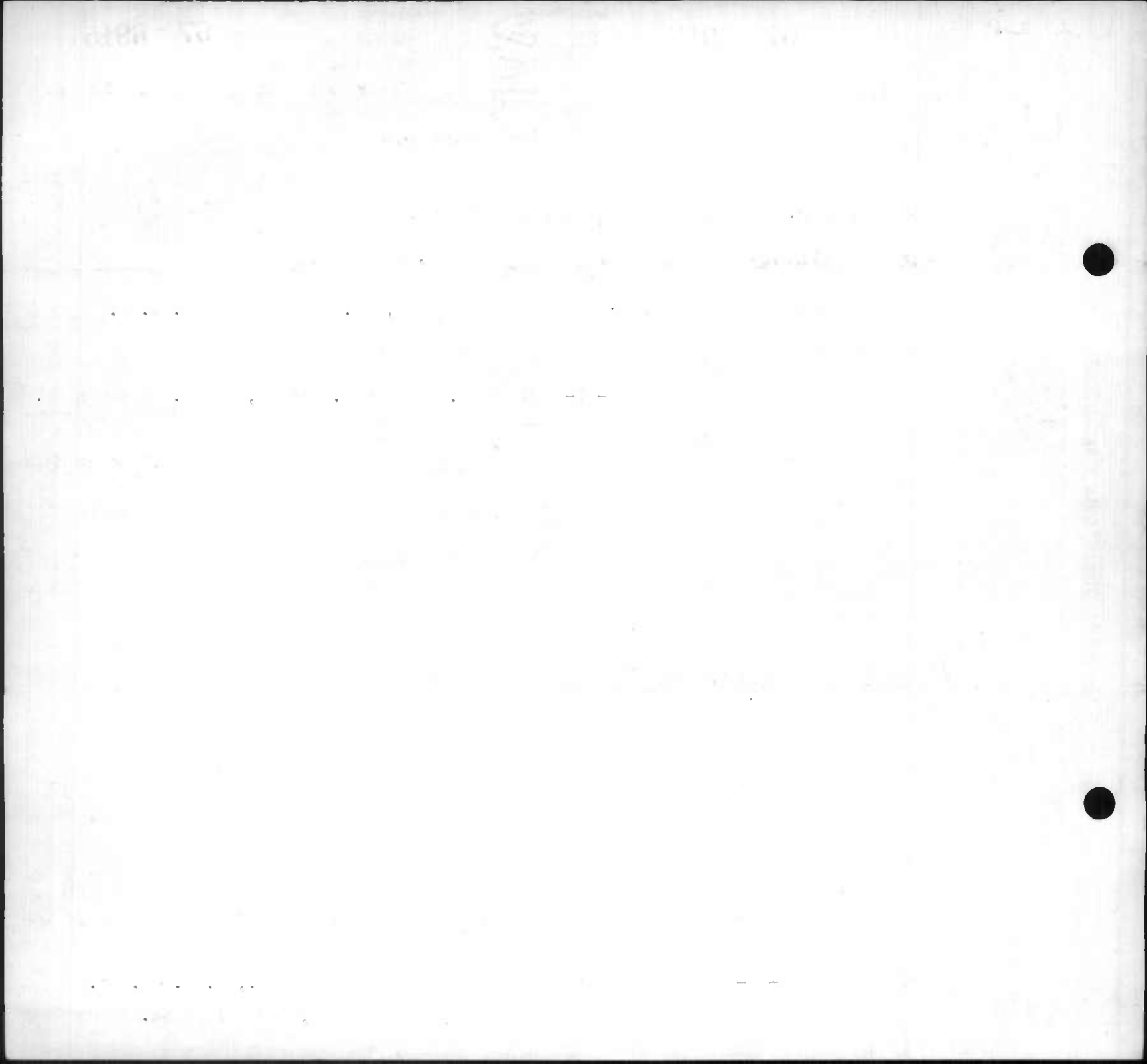
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6915				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6915	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>William S. Jacobs</u>				2. DATE AND HOUR OF DEATH <u>7-18-67</u> <u>12:20 P. M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hospital</u> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>21230</u> D. STREET ADDRESS (If rural, give location) <u>433 East Gittings Street</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>June 11, 1899</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Edward Jacobs</u>				
14. MOTHER'S MAIDEN NAME <u>Helen Martha Love</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>215-07-0403</u>			17. INFORMANT ADDRESS <u>Mrs. Dolores M. Jacobs, 433 E. Gittings St.</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>163X4-E9369</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Acute Coronary Occlusion</u>				CAUSE OF DEATH (A) DUE TO <u>Acute Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-10 min</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>2 mos.</u> <u>2 mos.</u>				(B) DUE TO <u>Carcinoma of Lung</u>			
(C) DUE TO <u>Hip Fracture</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>June 25 1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hip Fracture & Ca. of Lung</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>May 23 1967</u> to <u>July 18 1967</u> , that (I) (we) last saw the deceased alive on <u>July 18 (12:20) 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Artemio Argiaga Jr M.D.</u>				23B. DATE SIGNED <u>7-18-67</u>			
23C. PHYSICIAN'S NAME (Type) <u>ARTEMIO ARGIAGA JR M.D.</u>				23D. ADDRESS <u>10634 YORK ROAD COCKEYVILLE MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-21-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Ritchie Hwy., A. A. Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 20 1967</u>		25B. NAME OF REGISTRAR <u>R. E. E. E. E.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Flynn & Fleming, 1422 Light St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6916	
BIRTH NO. 67 6916		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Amos B. Armacost		2. DATE AND HOUR OF DEATH 7-16-67 12:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY Balto. Co.			
FULL NAME OF HOSPITAL OR INSTITUTION 44. UNION MEMORIAL HOSP.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. - timonium, md.			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2006 YORK RD.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 08-03-00	9. AGE (In years last birthday) 66	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Black & Decker		11. BIRTHPLACE (State or foreign country) md.	
13. FATHER'S NAME Joseph Armacost		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-01-7842		17. INFORMANT RAYMOND GILL	
18. 410X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Rheumatic heart disease - mitral + aortic stenosis + insufficiency			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Pulmonary thrombosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) w.k.w.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6-23 19 67 to 7-16 19 67 , that (1) (we) last saw the deceased alive on 7-15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank Palmisano M.D.				23B. DATE SIGNED 7-16-67	
23C. PHYSICIAN'S NAME (Type) FRANK S. PALMISANO, JR M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/19/67		24C. NAME OF CEMETERY or CREMATORY Salem E.U.B. Cemetery	
24D. LOCATION (City, town, or county) (State) Upperco Balto. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.			

THE NEW YORK PUBLIC LIBRARY

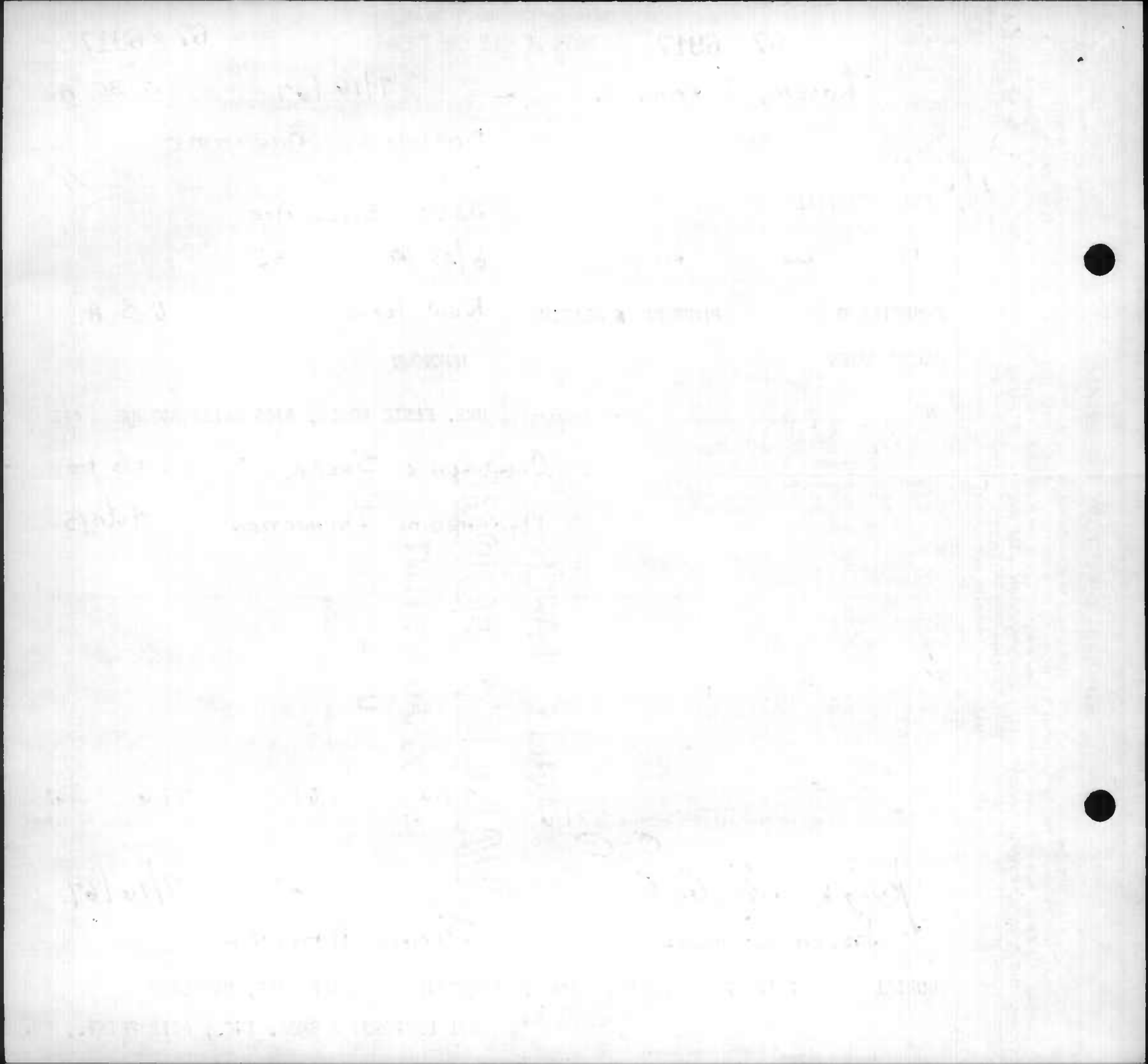
ASTEN LENOX TILDEN FOUNDATION

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
67 6917					CERTIFICATE OF DEATH					Registered No. 67 6917				
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) ROSEN, HERMAN M.				
2. DATE AND HOUR OF DEATH 7/16/67					3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3305 BELLE AVE				
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6/25/12		9. AGE (In years last birthday) 55		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR					10B. KIND OF BUSINESS OR INDUSTRY PLUMBING & HEATING					11. BIRTHPLACE (State or foreign country) NEW YORK				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME HARRY ROSEN					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. Unknown					17. INFORMANT MRS. ELSIE ROSEN, 3305 BELLE AVENUE #15				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I CARDIOGENIC SHOCK					CAUSE OF DEATH (A) DUE TO Myocardial Infarction					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. 4 days				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from 7/12 19 67 to 7/16 19 67 , that (2) (we) last saw the deceased alive on 7/16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Joseph Gimbel					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 7/16/67				
23C. PHYSICIAN'S NAME (Type) JOSEPH GIMBEL					23D. ADDRESS SINAI HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 7/17/67					24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)				
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					25A. DATE REC'D. BY HEALTH DEPT. JUL 20 1967					25B. NAME OF REGISTRAR Robert E. Fisher, M.D.				
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.					ADDRESS									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6918	
BIRTH NO. 67 6918		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GRANAT, ALTE		2. DATE AND HOUR OF DEATH 7/17/67 2:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		27-17	
		D. STREET ADDRESS (If rural, give location) 3332 AVONDALE AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/2/07	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Perlman		14. MOTHER'S MAIDEN NAME Leah?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Sigmund M. Granat - 3332 Avondale	
18. 420.11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIOGENIC SHOCK		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MYOCARDIAL INFARCTION		(B) DUE TO			
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7/16 19 67 to 7/17 19 67 , that (I) (we) last saw the deceased alive on 7/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Joseph S. Gimbel		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/17/67	
23C. PHYSICIAN'S NAME (Type) JOSEPH S. GIMBEL		M.D. 23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 18/67		24C. NAME OF CEMETERY or CREMATORY BETH ISRAEL	
24D. LOCATION (City, town, or county) (State) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR 6010 Rust Rd		ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6919	
BIRTH NO. 67 6919		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 7/15/67 3:00 AM	
1. NAME OF DECEASED (Type or Print) ALLEN KAHN		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE INC 42		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
5. SEX MALE 6. RACE CAU 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6/17/08 9. AGE (In years lost birthday) 59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIGHT CLUB 10B. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (State or foreign country) BALTIMORE MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB KAHN		14. MOTHER'S MAIDEN NAME FANNIE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT MRS. MIRIAM KAHN, 3647 GLENGYLE AVENUE, APT D3		ADDRESS ?	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION 17 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 6/27 to 7/15 1967, that (I) last saw the deceased alive on 7/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Ronald Daitch		23B. DATE, SIGNED 7/15/67	
23C. PHYSICIAN'S NAME (Type) RONALD DAITCH		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE, INC.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/17/67	
24C. NAME OF CEMETERY or CREMATORY BETH EL MEMORIAL PARK		24D. LOCATION RANDALLSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Paul E. Farber, MA	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		ADDRESS	

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STANTON HOSPITAL OF CHICAGO, INC.
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CHICAGO, IL 60601
6/12/12

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STANTON HOSPITAL OF CHICAGO, INC.
347 E. LAKE ST.
CHICAGO, IL 60601
6/12/12

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STANTON HOSPITAL OF CHICAGO, INC.
347 E. LAKE ST.
CHICAGO, IL 60601
6/12/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 6920	
CERTIFICATE OF DEATH				Registered No. 67 6920	
1. NAME OF DECEASED (Type or Print) Rose Green		2. DATE AND HOUR OF DEATH July 16, 1967 10:05 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 The Gundry Sanitarium, Inc.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Broadview Apts			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 7, 1880	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) New York, New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN			
14. MOTHER'S MAIDEN NAME UNKNOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS Mrs. Harry Green, 11 Slade Ave. Apt 206. 21208			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 334X1		CAUSE OF DEATH (A) DUE TO Cerebral and general Arteriosclerosis YrS			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) DUE TO (C)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No)	
21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21G. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21I. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct. 4, 1965 to July 16, 1967 , that (I) (we) last saw the deceased alive on July 16, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rachel K. Gundry				23B. DATE SIGNED July 16, 1967	
23C. PHYSICIAN'S NAME (Type) Rachel K. Gundry				23D. ADDRESS 2N. Wickham Rd. Baltimore, Md. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 7/18/67		24C. NAME OF CEMETERY OR CREMATORY Louden Park Crematory	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR W. J. Garrison		ADDRESS 4010 East Rd.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										67 6921			
BIRTH NO. 67 6921										Registered No. 67 6921			
M.E. CASE NO.													
1. NAME OF DECEASED (Type or Print) CHARLES H. DRIVER					2. DATE AND HOUR OF DEATH JULY 11, 1967 1:10 P.M.								
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)								
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSPITAL 38					A. STATE MARYLAND B. COUNTY PRINCE GEORGES CO.								
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BRANDYWINE 66-00								
					D. STREET ADDRESS (If rural, give location) 61 GIBBONS CHURCH ROAD								
5. SEX MALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 10/3/01		9. AGE (In years last birthday) 65		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Driver					14. MOTHER'S MAIDEN NAME Unknown								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 219-07-4473		17. INFORMANT Charles Driver, Jr. 1344 North Caroline Ave. N.E. D.C.					ADDRESS Wash., D.C.	
18. 33 IX I													
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH													
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)													
ANTECEDENT CAUSES													
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.													
II													
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/28 1967 to 7/11 1967 that (I) (we) last saw the deceased alive on July 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE Ronica M. Kluge M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										23B. DATE SIGNED July 11, 1967			
23C. PHYSICIAN'S NAME (Type) RONICA M. KLUGE										23D. ADDRESS UNIV. OF MD. HOSPITAL, BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 1967		24C. NAME OF CEMETERY or CREMATORY Gibbons Chr. Cemetery				24D. LOCATION (City, town, or county) (State) Brandywine, P. Ges. C. Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR Martell Adams				ADDRESS Aquasco, Md.	

BY POST TO THE
[Faint, illegible text follows, appearing to be a list or series of entries, possibly names and addresses, but too faded to transcribe accurately.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6922		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 6922	
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)		GEORGE RICHARD		2. DATE AND HOUR OF DEATH (SR)		July 18, 1967		4:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
002513 Reisterstown Rd Balto, Md				Maryland		Baltimore 13-04		2513 Reisterstown Rd	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7/11/89	9. AGE (In years lost birth day) 68	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman	11. BIRTHPLACE (State or foreign country) Athens, Georgia	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Garrett Richard		14. MOTHER'S MAIDEN NAME Rose Latner		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-10-1835-A		17. INFORMANT George Richard, Jr. (son) 3813 Boanney	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 162.7 I		CAUSE OF DEATH (A) DUE TO metastatic Carcinoma to liver (B) DUE TO Oat cell Carcinoma of lung (C) DUE TO none		INTERVAL BETWEEN ONSET AND DEATH unk.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION June 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Sinai Hospital		19C. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from that (I) (we) last saw the deceased alive on and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		attended at Sinai Hospital until 7/18 1967		and that in (my) (our) opinion death occurred on the date					
23A. SIGNATURE Stewart		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/18/67					
23C. PHYSICIAN'S NAME (Type) D. W. STEWART		23D. ADDRESS Sinai Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-22-67		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.			

James H. Lee, 402 Madison Ave.
New York, N.Y.

W. J. Lee

1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6923	
<div style="display: flex; justify-content: space-between;"> 5-416 67 6923 CERTIFICATE OF DEATH </div>					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Silverstein, Mr Myer</i>	
2. DATE AND HOUR OF DEATH <i>7/17/67</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>St. Bon Secours Hosp. Baltimore, Md.</i>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland.</i> B. COUNTY <i>Baltimore</i>		5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		8. DATE OF BIRTH <i>4/18/95</i>		9. AGE (In years last birthday) <i>72</i>	
D. STREET ADDRESS (If rural, give location) <i>3717 Springdale Ave</i>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>POLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Joel</i>		14. MOTHER'S MAIDEN NAME <i>Dora</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-03-4905</i>		17. INFORMANT <i>WIFE</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>G.I Tract Hemorrhage</i>		CAUSE OF DEATH (A) DUE TO <i>Ca of Colon.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Hours.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Arteriosclerotic C.V. Dis, Diabetes</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (the hospital) attended the deceased from <i>Jan. 1963</i> to <i>July 17 1967</i> , that (1) (he) last saw the deceased alive on <i>July 17 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Letter A. Wall Jr.</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/17/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>LETTER A. WALL JR.</i>		23D. ADDRESS <i>1039 St Paul St 21202</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/18/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Carmel</i>	
24D. LOCATION (City, town, or county) (State) <i>Balta Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 20 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Sylvan S. Lewis & Son, INC</i>			
25D. ADDRESS <i>Garrison, Md</i>					

The above is a copy of the
 original, and is
 in full accordance with the
 original.

The above is a copy of the
 original, and is
 in full accordance with the
 original.

The above is a copy of the
 original, and is
 in full accordance with the
 original.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 6924 CERTIFICATE OF DEATH					Registered No. 67 6924					
BIRTH NO. _____					M.E. CASE NO. _____					
1. NAME OF DECEASED (Type or Print) <i>Herr, George</i>					2. DATE AND HOUR OF DEATH <i>7/18/67 5:30A, M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Duland Nursing Home</i> <i>1501 Duland St.</i>					A. STATE <i>Maryland</i>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21-02</i>					
D. STREET ADDRESS (If rural, give location) <i>100 W. Cross Street</i>										
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>7/7/95</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sewer</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Broom Factory</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>William J. Herr</i>					14. MOTHER'S MAIDEN NAME <i>Alice Eyerly</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. _____		17. INFORMANT <i>Duland Nursing Home</i>			ADDRESS <i>1501 Duland St.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>MALIGNANT CANCER</i> DUE TO (B) <i>BRONCHOGENIC CARCINOMA</i> DUE TO (C) _____					
					INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i> <i>1 year</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>7-29-67</i> to <i>18 July</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>18 July</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Emerson C. Walden</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>18 July 67</i>		
23C. PHYSICIAN'S NAME (Type) <i>Dr. Emerson C. Walden</i>					23D. ADDRESS M.D. <i>2329 Harlem Avenue, Balto., Md. 21216</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>7/21/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Cross</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 20 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>Joseph Ambrose</i>			ADDRESS <i>1328 Sulphur Sp. Rd.</i>	

1950 No.

1950 No.

1950 No.

1950 No.

1950 No.

1950 No.

1950 No.

1950 No.

1950 No.

1950 No.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-6357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 6925

BIRTH NO.

67 6925

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

THOMAS A. JORDAN

2. DATE AND HOUR OF DEATH

JULY 18 1967 6:10 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

35 CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

MARYLAND

D. STREET ADDRESS (If rural, give location)

2405 Mc Elderry St.

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1-10-94

9. AGE (In years
last birthday)

73

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF
WHAT COUNTRY?

AMERICAN

13. FATHER'S NAME

CHARLES JORDAN

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT

ADDRESS

Mrs. Edna E. Jordan 2405 Mc Elderry St.

18. I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

PULMONARY EDEMA - months

(B) DUE TO

ARTERIOSCLEROTIC HEART DISEASE
CORONARY HEART FAILURE 1 year

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/18/67 (5 PM) 1967 to 7/18/67 (6:10 PM) 1967 that (I) (we) last saw the deceased alive on 7/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ephraim B. Barzaga

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

July 18, 1967

23C. PHYSICIAN'S NAME (Type)

EPHRAIM BARZAGA

23D. ADDRESS

M.D.

CHURCH HOME & HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7 24 67

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill

24D. LOCATION

(City, town, or county)

(State)

Brooklyn, A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 20 1967

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

130 E. Fort Ave.

February 11, 1917
Epworth, Kansas

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-2601

BALTIMORE CITY HEALTH DEPARTMENT

67 6926 CERTIFICATE OF DEATH

Registered No.

67 6926

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

YEAGER, LEODA MAE

2. DATE AND HOUR OF DEATH

16 JULY 1967 1:30 P.M. EDT

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY MD. CUMBERLAND Allegany Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

CUMBERLAND

D. STREET ADDRESS (If rural, give location)

11 THOMPSON AVE

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12/17/25

9. AGE (In years)

41

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF

WHAT COUNTRY? U.S.

13. FATHER'S NAME

RAYMOND ZIMERLA

14. MOTHER'S MAIDEN NAME

MARIE ZINK

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. Harry R. Yeager Cumberland MD

ADDRESS

18. 45-2X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) BRAIN STEM FAILURE

24 h.

DUE TO

(B) CEREBRAL EDEMA.

3 days.

DUE TO

(C) ~~AND~~ POST OPERATIVE CLIPPING

3 days

MIDDLE CEREBRAL ANEURYSM, LEFT

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

7/13/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

MIDDLE CEREBRAL ARTERY ANEURYSM, LEFT.

20A. AUTOPSY? (Yes or No)

No.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21G. WHILE AT WORK

21H. NOT WHILE AT WORK

22. I certify that (I) (this hospital) attended the deceased from 7/8 1967 to 7/16 1967.

that (I) (we) last saw the deceased alive on 7/16 1967 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ronald L. Paul

M.D.

Attending Phys.

Med. Director

Self Phys.

23B. DATE SIGNED

7/16/67

23C. PHYSICIAN'S NAME (Type)

RONALD L. PAUL

M.D.

23D. ADDRESS

UNIVERSITY OF MARYLAND HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/19/67

24C. NAME OF CEMETERY or CREMATORY

Hillcrest Burial Ph.

24D. LOCATION

Cumberland MD.

25A. DATE REC'D BY HEALTH DEPT.

JUL 20 1967

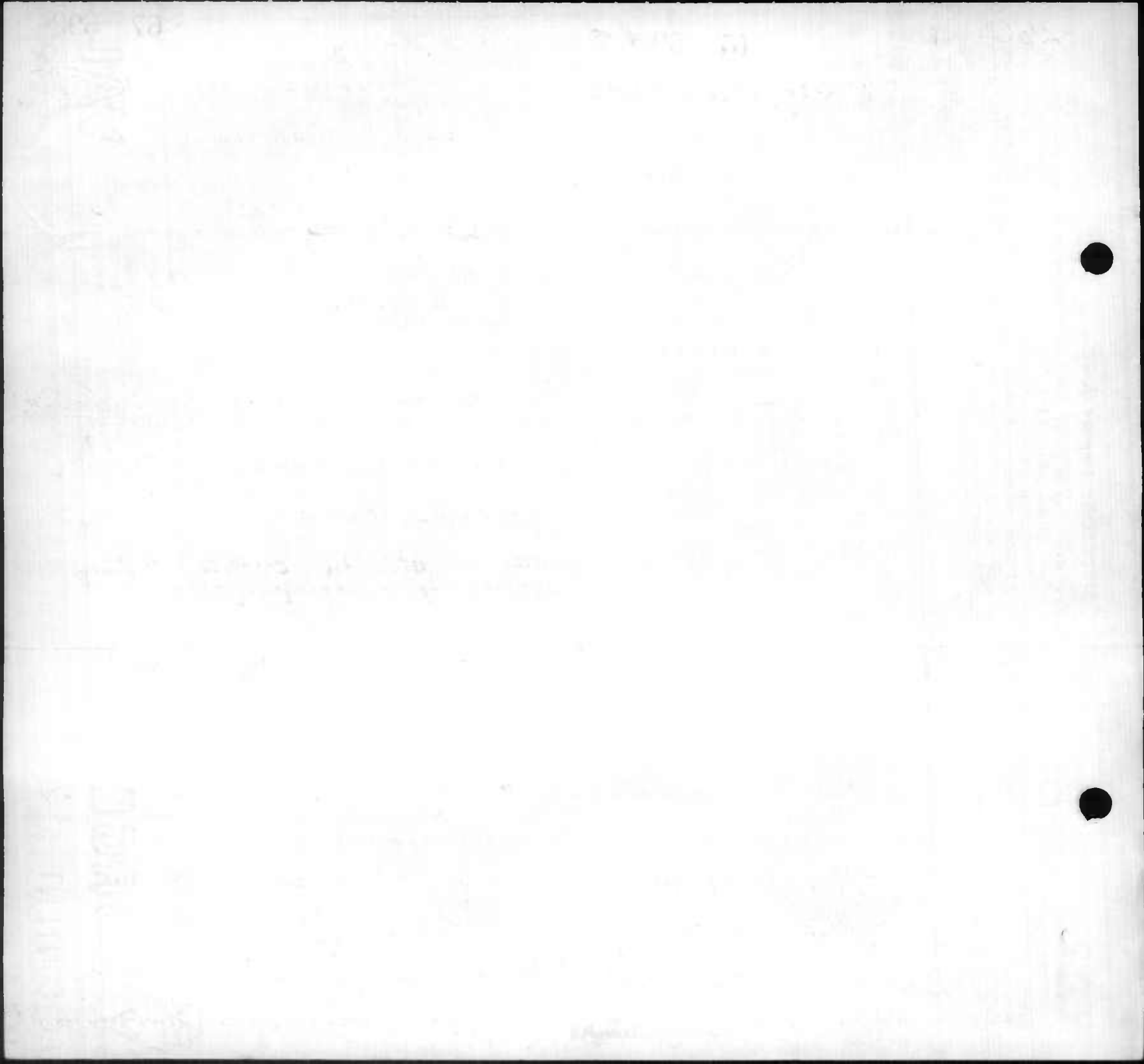
25B. NAME OF REGISTRAR

John E. Talbot

25C. FUNERAL DIRECTOR

Louis Stein Inc. Cumberland MD

ADDRESS



1
M-640

67 6927

BALTIMORE CITY HEALTH DEPARTMENT

67 6927

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

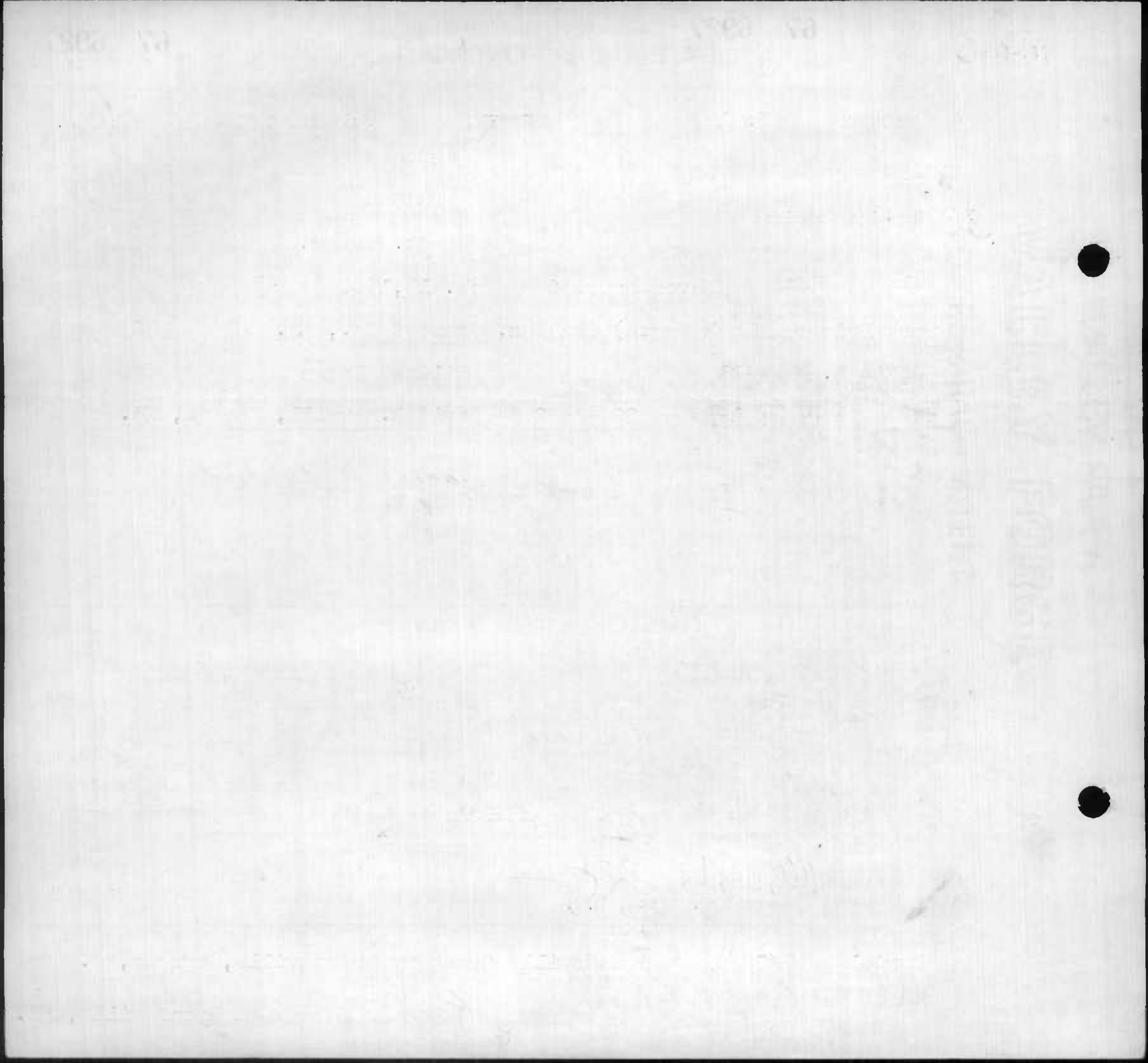
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ROBERT Paul MERRILL		2. DATE AND HOUR PRONOUNCED DEAD July 16, 1967 8:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 4-01	
FULL NAME OF HOSPITAL OR INSTITUTION Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 316 St. Paul St.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH Feb. 19, 1940
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver (Chuck Wagon) Own Bus.		10B. KIND OF BUSINESS OR INDUSTRY Garrett Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME David R. Merrill		14. MOTHER'S MAIDEN NAME Mildred Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service) Yes 1957 to 1960		16. SOCIAL SECURITY NO. 220-34-2034	
		17. INFORMANT David R. Merrill, Barton, Md.	

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subarachnoid Hemorrhage Traumatic		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2/13/67	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Sidewalk	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5600 blk. Pulaski Hwy.	
21D. TIME OF INJURY (APPROX.) 7/13/67 8:00 p.m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Subj. involved in fight in bar room	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7/20/67	23C. NAME OF CEMETERY or CREMATORY Grantsville Cemetery
24A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		24B. NAME OF REGISTRAR Robert E. Farley, M.D.	24C. FUNERAL DIRECTOR Ruth Newman
		24D. LOCATION (City, town, or county) (State) Grantsville, Garrett, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-14991</u> <u>67</u> <u>6928</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67</u> <u>6928</u>	
M.E. CASE NO.		1. NAME OF DECEASED <u>PAULA ANNE</u> (Type or Print)		2. DATE AND HOUR OF DEATH <u>7-17-67</u> <u>7:15 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>34 BON SECOURS HOSPITAL</u> 8-7-67		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Ind.</u> B. COUNTY <u>Balto Co.</u>			
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>INFANT</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		8. DATE OF BIRTH <u>7-17-67</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		9. AGE (In years last birthday) <u>14</u> <u>55</u>	
13. FATHER'S NAME <u>MICHAEL ALLISON</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE PAUZA</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> <u>53-00</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Michael Allison - Apt 214 A Preston Court.</u>	
18. <u>762.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Stroke</u> DUE TO (B) <u>as determined</u> DUE TO (C) _____		ADDRESS (121228) INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-17</u> 19 <u>67</u> to <u>7-17</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-17</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Estrellita P. Trias, M.D.</u>		23B. DATE SIGNED <u>7-17-67</u>		23C. PHYSICIAN'S NAME (Type) <u>ESTRELLITA P. TRIAS M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/19/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Mary Redemptor</u>	
24D. LOCATION (City, town, or county) (State) <u>4430 Belair Rd/Balto. Ind.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 20 1967</u>		25B. NAME OF REGISTRAR <u>John J. Brown</u>	
25C. FUNERAL DIRECTOR <u>Hollins St. Balto. Ind.</u>		25D. ADDRESS <u>901</u>			

Name added from B.C. 67-14991
8-7-67

M.H.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 6929					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 6929				
1. NAME OF DECEASED (Type or Print) EMGE, WILLIAM A.					2. DATE AND HOUR OF DEATH 07/17/67 4:30 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balti. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228 D. STREET ADDRESS (If rural, give location) 412 WAVELAND RD.				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/07/06	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-STAND.OIL			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME AUGUST EMGE					14. MOTHER'S MAIDEN NAME LOUISE DAUTRICH				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213058298		17. INFORMANT ADDRESS ST AGNES RECORDS-CATON & WILKENS AVE.				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of lungs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 6 19 67 to JULY 17 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 17 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death.									
23A. SIGNATURE Fomualdo R. Dato					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED JULY 17, 1967		
23C. PHYSICIAN'S NAME (Type) Fomualdo R. Dato					23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/20/67		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK		24D. LOCATION (City, town, or county) (State) BALTO. MD.			
25A. DATE JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR E.S. MACNABB		ADDRESS 301 FREDERICK RD 21228			

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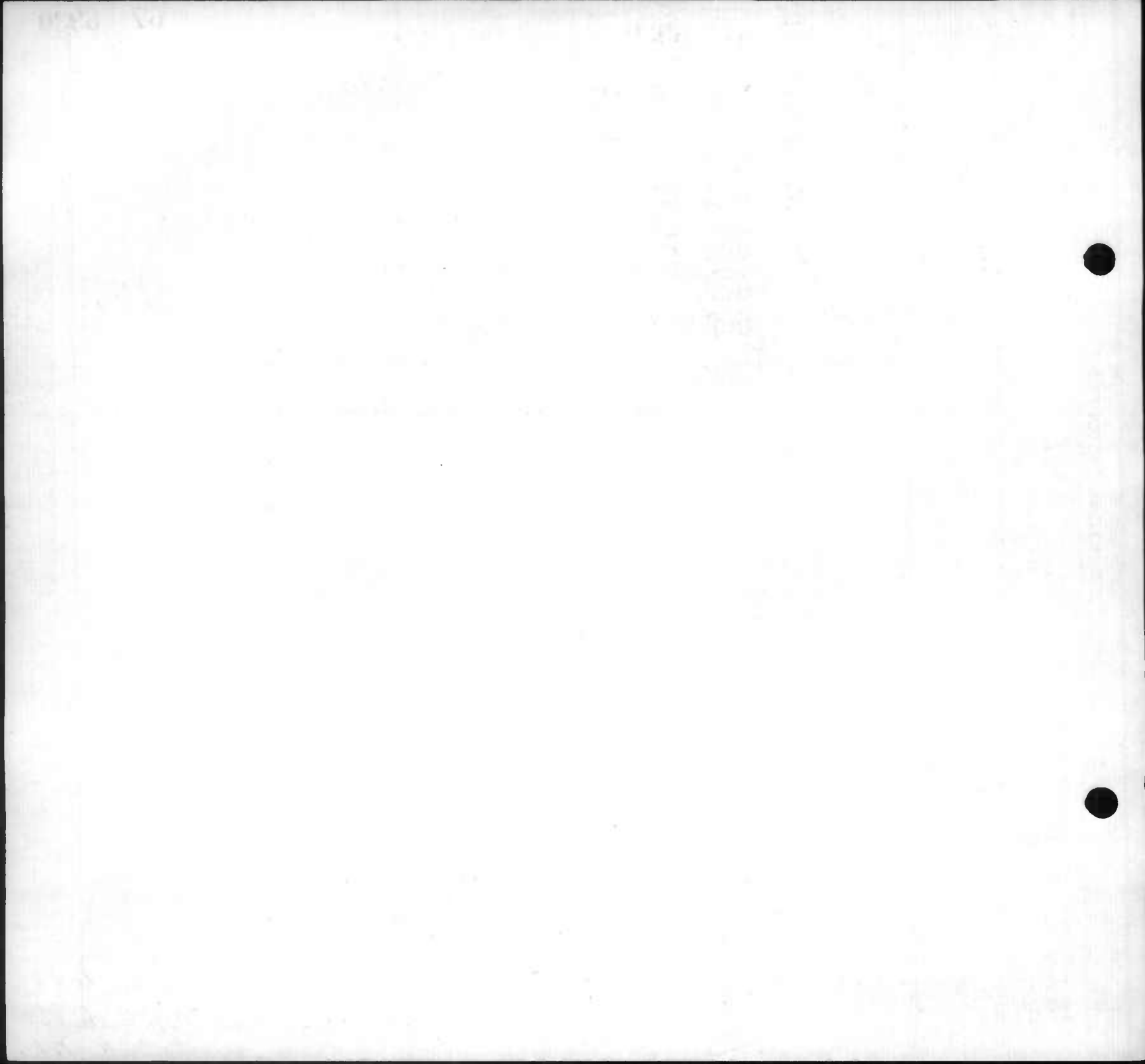
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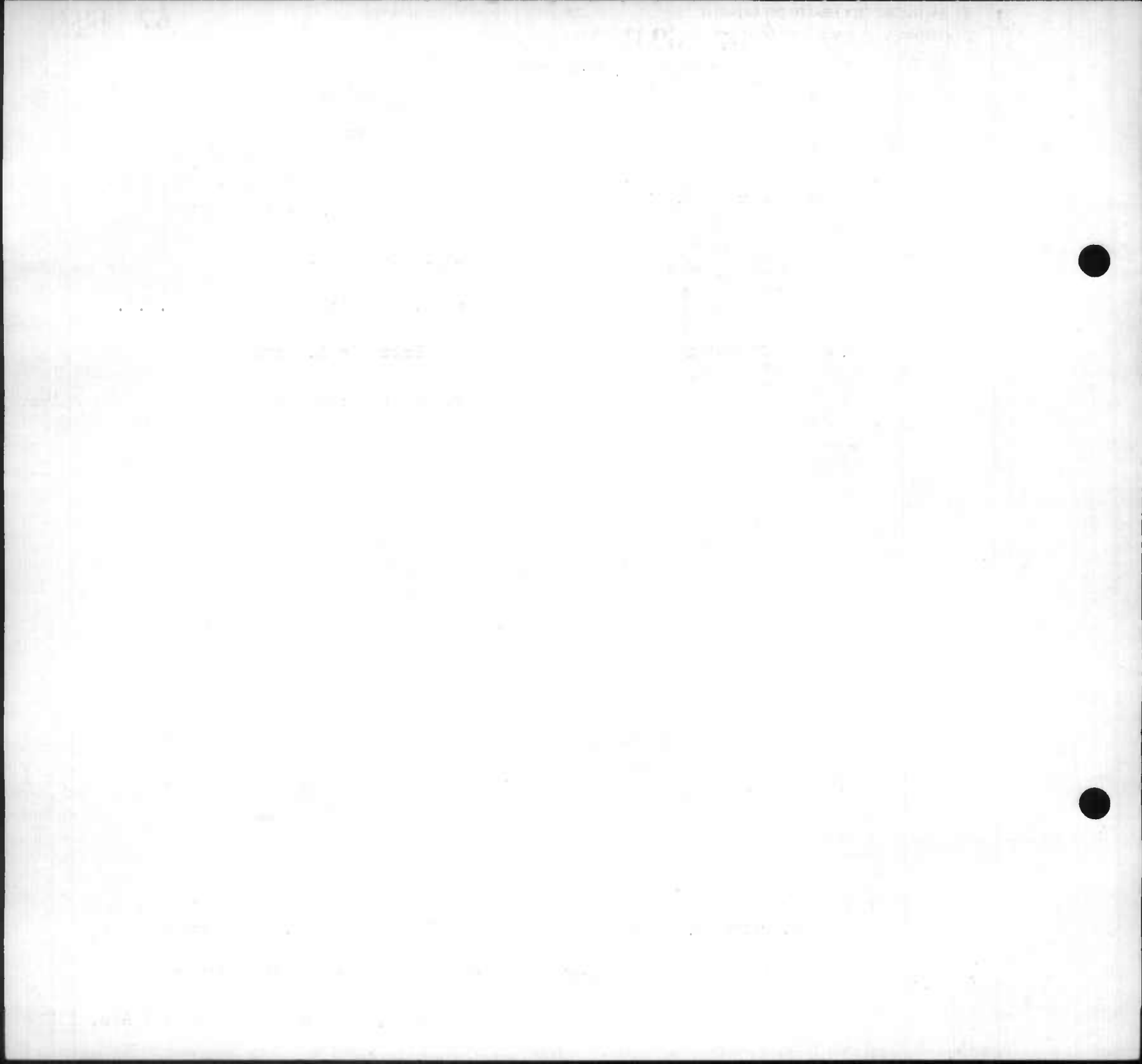
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6930 CERTIFICATE OF DEATH					Registered No. 67 6930				
BIRTH NO. 67 6930					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) CECILIA KING					2. DATE AND HOUR OF DEATH 7/18/67 2:45 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 902 W. Lombard St.					A. STATE Ind.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balti.				
					D. STREET ADDRESS (If rural, give location) 902 W. Lombard St. - (21223)				
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) divorced	8. DATE OF BIRTH 3/3/1917	9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress			10B. KIND OF BUSINESS OR INDUSTRY Dairy Cream		11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harry King					14. MOTHER'S MAIDEN NAME Margaret M. Garvey				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 219-01-3185		17. INFORMANT ADDRESS Mary King - 902 W. Lombard St.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Ca -					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from May - 10 1967 to July 18 1967 , that (I) (we) last saw the deceased alive on July 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Charles Commasello M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 19/67		
23C. PHYSICIAN'S NAME (Type) Charles Commasello					23D. ADDRESS 900 W. Lombard St.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/22/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Ind.		
25A. DATE RECD BY HEALTH DEPT. JUL 20 1967			25B. NAME OF REGISTRAR Robert E. Fidelity		25C. FUNERAL DIRECTOR ADDRESS John J. Cowan - Son Inc. 901 Hollis St. Balt. Ind.				

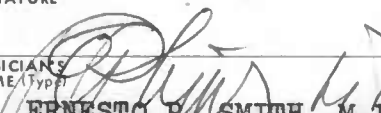


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 62-19134 67		6931		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VICTORIA A. CANDELORO		2. DATE AND HOUR OF DEATH July 17, 1967 10:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 00 4116 Edmondson Ave. Baltimore, Md. 21229		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 628 Lucia Ave. 21229			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 7-13-1962	9. AGE (In years last birthday) 5	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Candeloro			
14. MOTHER'S MAIDEN NAME Patricia A. Herrick		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Thomas Candeloro 4116 Edmonson Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 325.3 I BRONCHOPNEUMONIA, severe tract infection dehydration mental retardation		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 wks since infancy	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Epilepsy secondary to intracranial hemorrhage at infancy			
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from 9-10-1962 to 7-17-1967 , that (I) (we) last saw the deceased alive on 7-16-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Harry L. Knipp		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-17-67	
23C. PHYSICIAN'S NAME (Type) Dr. Harry L. Knipp		23D. ADDRESS 4116 Edmondson Ave.		23E. PHONE NO. LO 6 - 1656	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-20-67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. JUL 20 1967			
25B. NAME OF REGISTRAR Robert E. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 6932
67 6932		CERTIFICATE OF DEATH		Registered No. <u>67 6932</u>
BIRTH NO.		M.E. CASE NO.		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
GUNN, GEORGE GERALD		7/18/67 10:30 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4317 HIGHVIEW AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4/13/17	9. AGE (In years last birthday) 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLOCK LAYER		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME JAMES WALTE GUNN		12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1/25/43-10/15/45		16. SOCIAL SECURITY NO. 212-14-15-53		17. INFORMANT RECORDS
18. I		ADDRESS V.A. HOSPITAL, BALTIMORE, MD. 21218		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CARCINOMA OF THE STOMACH WITH METASTASES TO BOTH LUNGS. (B) DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO.
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 30 19 67 to JULY 18 19 67, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 18 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.				
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/19/67
23C. PHYSICIAN'S NAME (Type) ERNESTO P. SMITH, M.D.		23D. ADDRESS V.A. HOSPITAL, BALTIMORE, MD. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/22/67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery
24D. LOCATION Baltimore		Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Howard H. Hubbard
		ADDRESS 4107 Wilkens Ave. 21229		

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67 6933 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6933

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES T. CLEGG

2. DATE AND HOUR PRONOUNCED DEAD

July 18, 1967

8:25 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)31 Baltimore
City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - Dundalk

D. STREET ADDRESS (If rural, give location)

1751 Melbourne Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

May 27, 1954

9. AGE (In years
last birthday)

13

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

James W. Clegg

14. MOTHER'S MAIDEN NAME

Olive Kingston

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
None

17. INFORMANT (Father)

ADDRESS Dundalk, Md.

Mr. James W. Clegg, 1751 Melbourne Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Congenital heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/21/67

23C. NAME OF CEMETERY OR CREMATORY

Holly Hill Mem, Gardens Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 20 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				67 6934		CERTIFICATE OF DEATH		Registered No. 67 6934	
BIRTH NO. 67 6934				M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANGELO CLEMENTONI			
2. DATE AND HOUR OF DEATH				JULY 18, 1967		2:37 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
35 CHURCH HOME & HOSPITAL				Church Home & Hospital		A. STATE B. COUNTY MARYLAND Baltimore Co.			
5. SEX MALE				6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			
8. DATE OF BIRTH DEC. 2, 1890				9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION WORKER			
11. BIRTHPLACE (State or foreign country) ITALY				12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BEOGO CLEMENTONI			
14. MOTHER'S MAIDEN NAME GUISEPPI (HALL)				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-01-0363			
17. INFORMANT (Wife) Mrs. Adilina Clementoni, 3137 Yorkway				18. ADDRESS Dundalk, Md. 21222		19. CAUSE OF DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH			
18. ANTECEDENT CAUSES				(B) DUE TO					
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-29 19 67 to 7-18 19 67 .				that (I) (we) lost saw the deceased alive on 7-18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John J. Duda				M.D. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-18-67			
23C. PHYSICIAN'S NAME (Type) Joseph S. Hefner				M.D. <input type="checkbox"/>		23D. ADDRESS Church Home & Hospital, Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/21/67		24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECD BY HEALTH DEPT. JUL 20 1967				25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.			

Epinephelus

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6935	
BIRTH NO. 67 6935		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Frank Rosemark			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH 7-19-67 4:15 P M.			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Little Sisters of the Poor 1200 Valley St., Balt. Md. 21202		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1200 Valley St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 3-15-1875	9. AGE (In years last birthday) 92	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? Yes USA		13. FATHER'S NAME Joseph		14. MOTHER'S MAIDEN NAME Mary Organiska	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-54-3389T		17. INFORMANT ADDRESS Little Sisters of the Poor	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage 3 days		(A) DUE TO A.S.C.V.D.		(B) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on 7-18-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-19-67	
23C. PHYSICIAN'S NAME (Type) Justin Kudirka		23D. ADDRESS M.D. 2151 Wilkins Ave., Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/21/67		24C. NAME OF CEMETERY OR CREMATORY Cathedral	
				24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Philip Herwig Sons Orleans St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6936		CERTIFICATE OF DEATH		67 6936	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)			
		JOHN PERRY (KRUSZEWSKI) (KROUCHESKI)			
2. DATE AND HOUR OF DEATH		JULY 18 1967 3 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND			
24 N. LAKEWOOD AVE.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location)		24 N. LAKEWOOD AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
M	W	MARRIED	1890	77	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SELF EMPLOYED		SALVAGE CO.		PENNSYLVANIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
P KRUSZEWSKI		UNKNOWN		NO	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
24-16-3648		GERTRUDE PERRY		24 N. LAKEWOOD AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
CORONARY THROMBOSIS		Instant		3 yrs.	
EMPHYSEMA		5 yrs.			
CHRONIC MYOCARDITIS					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 2 1967 to July 18 1967, that (I) (we) last saw the deceased alive on July 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. died,		23A. SIGNATURE		23B. DATE SIGNED	
John V. Sczerbicki		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		7-19-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. NAME OF REGISTERED	
John V. Sczerbicki		1802 Eastern Ave 31 Md		Robert E. Taylor, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		7-22-67		HOLY ROSARY CEM.	
24D. LOCATION (City, town, or county)		24E. STATE		24F. FUNERAL DIRECTOR	
BALTO		MD		JOHN M. WEDERT & SONS INC 4013 CHESTER ST	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
JUL 20 1967		Robert E. Taylor, M.D.			

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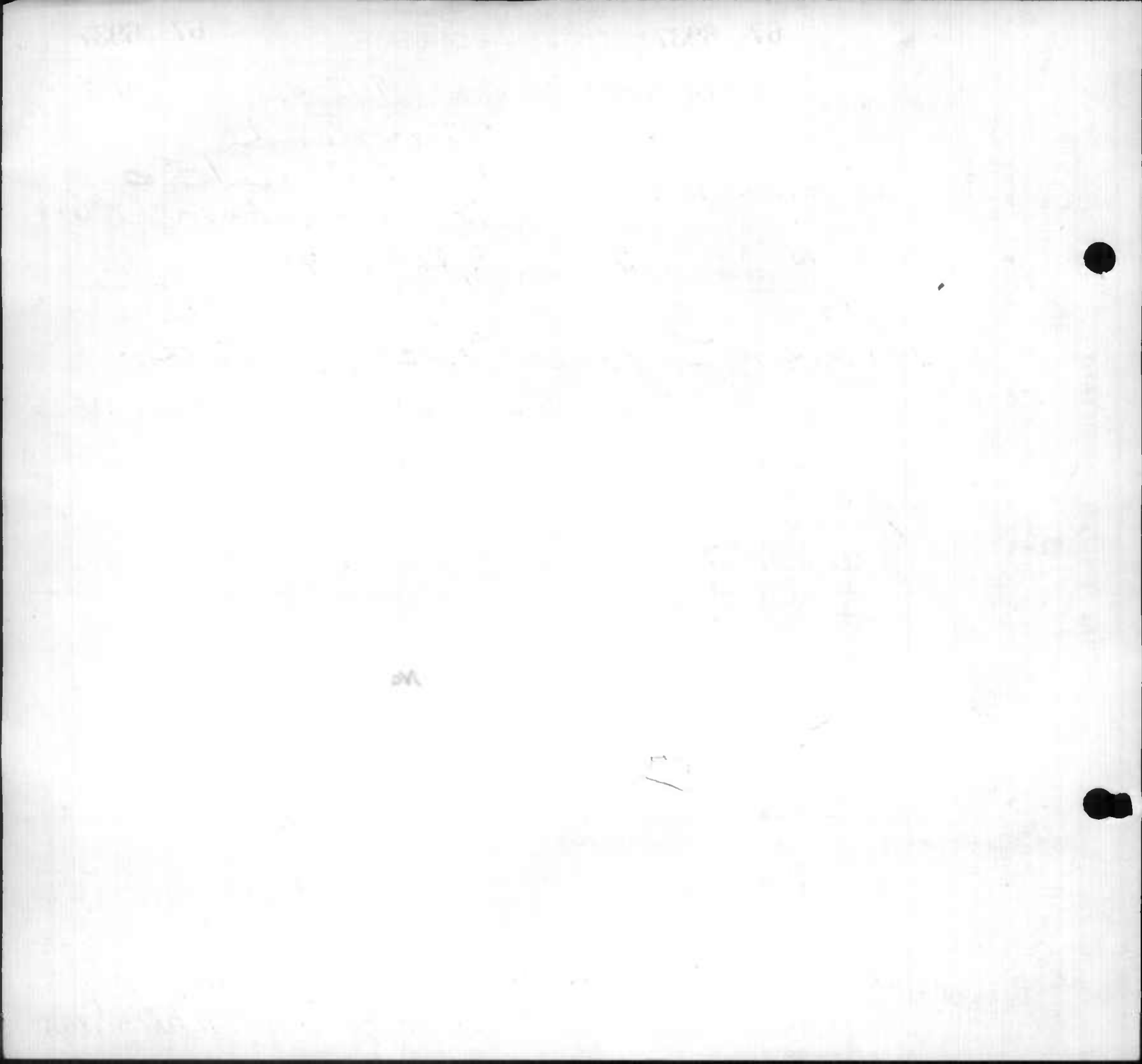
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FUNERAL DIRECTOR: IMPORTANT

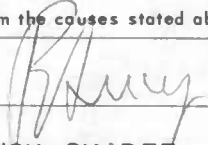
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6937		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6937	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VIRGINIA R. LOGAN		2. DATE AND HOUR OF DEATH 7-17-67 4:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 8-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 130 D. STREET ADDRESS (If rural, give location) 1623 EARECKSON PLACE			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) D	8. DATE OF BIRTH 9/22/21	9. AGE (In years last birthday) 45	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harrison Logan		14. MOTHER'S MAIDEN NAME Mary Stanton	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-18-9876		17. INFORMANT ADDRESS JOHN LOGAN 1623 EARECKSON PLACE	
18. CAUSE OF DEATH 5-81.01		INTERVAL BETWEEN ONSET AND DEATH 9 months			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Hepatic Insufficiency		(B) DUE TO	
(C) DUE TO NUTRITIONAL LIVER DISEASE		YEARS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ANURIA					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-13 1967 to 7-17 1967, that (I) (we) last saw the deceased alive on 7-17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Michael Vincent M.D.				23B. DATE SIGNED 7-17-67	
23C. PHYSICIAN'S NAME (Type) G. MICHAEL VINCENT M.D.				23D. ADDRESS JOHNS HOPKINS HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-22-67		24C. NAME OF CEMETERY or CREMATORY MT CALVARY	
24D. LOCATION (City, town, or county) (State) a.a. COUNTY MD.					
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS JOSEPH KNIGHT 1639 N. BROADWAY	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6938	
BIRTH NO. 67 6938		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WALTER N. BRUNO		07/18/67 10:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
<div style="text-align: center;"> CERTIFICATE AMENDED <small>(If not in hospital or institution, give street address or location)</small> 40 ST AGNES HOSPITAL CATON & WILKENS AVE BALTIMORE 21229, MD </div>		A. STATE		B. COUNTY	
		MARYLAND		MARYLAND	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE		28-04	
		D. STREET ADDRESS (If rural, give location)			
		4605 MANORDENE RD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	MARRIED	03/13/90	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
UNKNOWN Retired		B alto. City Fire Dept.		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
WALTER		NOT KNOWN		U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNKNOWN		216 28 1061		Mrs. Grace F. Bruno HOSPITAL RECORDS-ST AGNES HOSPITAL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Metastatic Carcinoma (B) of the Liver (C) (Terminal)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 06/16/ 19 67 to 07/18/ 19 67, that (XX) we last saw the deceased alive on 07/18/ 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (X) (did) (XX) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<div style="text-align: center;">  RAMON SUAREZ </div>				7/18/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		ST AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/22/67		Lorraine Park Cem.	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 20 1967		Robert E. Taylor		Witzke F. D. - 4101 Edmondson Av.	

V.S153

7-24-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5w-25

BALTIMORE CITY HEALTH DEPARTMENT 67 6939 CERTIFICATE OF DEATH

Registered No.

67 6939

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William H. Wehrenberg

2. DATE AND HOUR OF DEATH

July 17, 1967

2 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

1217 Washington Blvd.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

21-02

D. STREET ADDRESS (If rural, give location)

1217 Washington Blvd.

5. SEX

M

6. RACE

Cauc.

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan. 11/89

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance Man

10B. KIND OF BUSINESS OR INDUSTRY

Union Trust Co.

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Late - Ernest Wehrenberg

14. MOTHER'S MAIDEN NAME

Elizabeth

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

214-14-7426 A

17. INFORMANT

Mr. Henry Wehrenberg

ADDRESS

1217 Washington Blvd. - 21230

18.

153.81

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Carcinoma Colon

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

7 months

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/3 1960 to 7/17 1967.
that (I) (we) last saw the deceased alive on 7/17 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John P. Urlock Jr.

M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

7/18/67

23C. PHYSICIAN'S
NAME (Type)

John P. Urlock JR.

M.D.

23D. ADDRESS

1227 Washington Blvd. - 21230

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/20/67

24C. NAME OF CEMETERY or CREMATORY

St. Paul, Violetville

24D. LOCATION

(City, town, or county)

Balto., Md.

(State)

25A. DATE REC'D. BY HEALTH DEPT.

JUL 20 1967

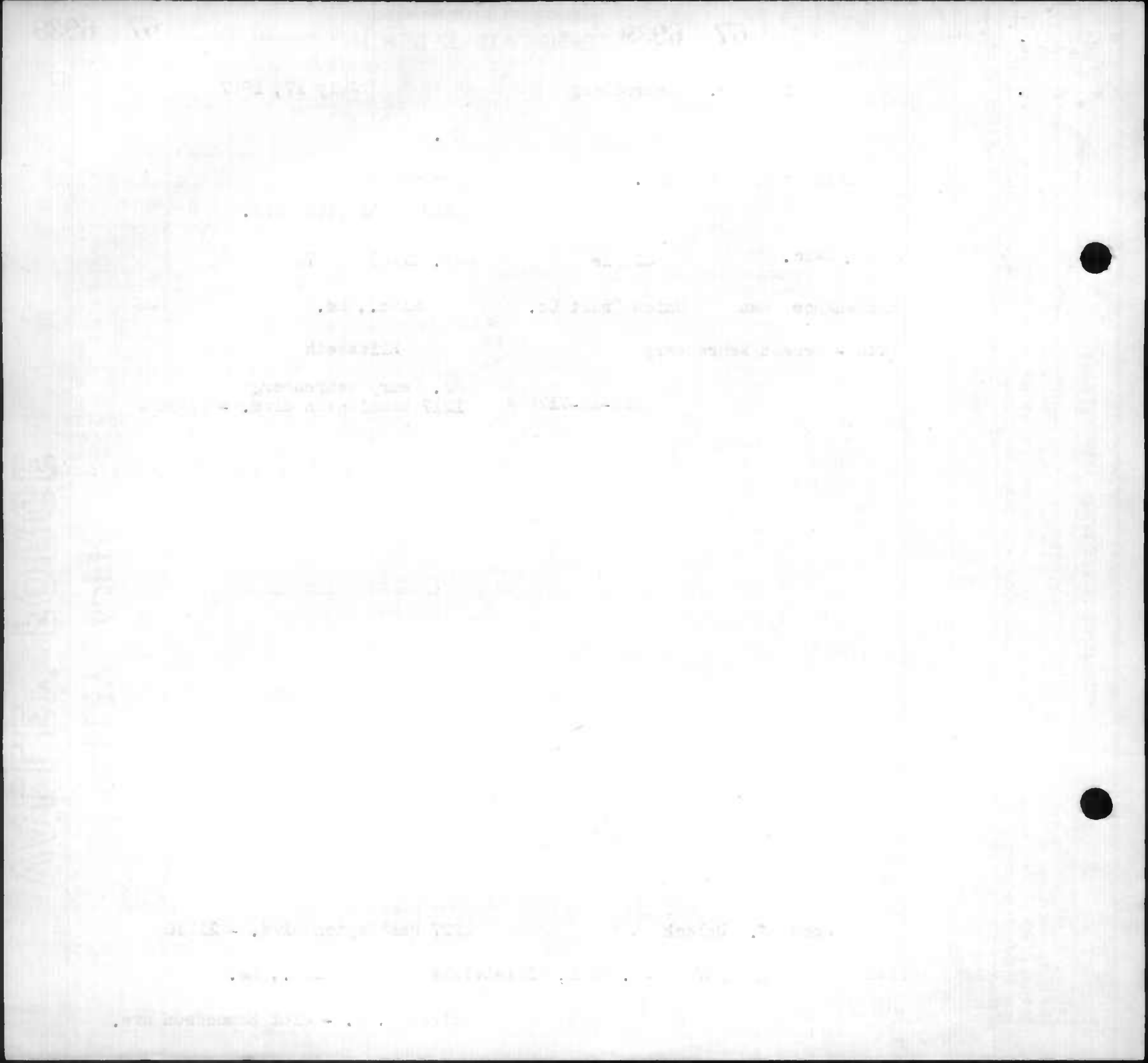
25B. NAME OF REGISTRAR

Robert E. Fickens

25C. FUNERAL DIRECTOR

Witzke F. D. - 4101 Edmondson Ave.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 6940		67 6940	
BIRTH NO.		67 6940		REGISTERED NO.		67 6940	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>JOHN W. McIVER</u>			
2. DATE AND HOUR OF DEATH <u>7/18/67</u> <u>9:40 A.M.</u>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO. Co.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSP.</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>53-00</u>			
				D. STREET ADDRESS (If rural, give location) <u>5621 Edmondson Ave</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3-4-95</u>	9. AGE (In years last birthday) <u>72</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - laborer</u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Industry</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JOHN M McIVER</u>			14. MOTHER'S MAIDEN NAME <u>MARGARET HEWITT</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213-07-5248</u>		17. INFORMANT <u>SISTER</u> Mrs. John W. McIVER 5621 Edmondson Av.		
18. <u>332X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ASPIRATION PNEUMONIA</u> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Subarachnoid Hemorrhage</u> DUE TO <u>CEREBRAL INFARCTION</u> DUE TO <u>CEREBRAL THROMBOSIS</u>				<u>2 months</u> <u>2 mos.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pulmonary Embolism</u>							
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NONE</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>5-3</u> 19 <u>67</u> to <u>7-18</u> 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>7-18</u> 19 <u>67</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> <u>not</u> view the body after death.							
23A. SIGNATURE <u>Frank J. Zorick</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-18-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANK J. ZORICK</u>				23D. ADDRESS <u>—</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/21/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 20 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Feltman</u>		25C. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Av.</u>		ADDRESS	

100-100000-100000

100-100000-100000

100-100000-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6941		BALTIMORE CITY HEALTH DEPT.		Registered No. 67 6941	
M.E. CASE NO.		CERTIFICATE OF DEATH		M.	
1. NAME OF DECEASED (Type or Print) SHAUM, MISS OLGA J. SHAUM		2. DATE AND HOUR OF DEATH At 12-05 AM on 7/19/1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 6-03 <input checked="" type="checkbox"/> CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21231 D. STREET ADDRESS (If rural, give location) 435 N. PATTERSON PK. AVE (31)			
5. SEX A	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 1-18-96	9. AGE (In years last birthday) 71 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cr. Sec. Co.		10B. KIND OF BUSINESS OR INDUSTRY Telephone Company		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David C. Shaum - Deceased		14. MOTHER'S MAIDEN NAME Mary S. Shaub - Deceased	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 212-05-11574		17. INFORMANT Robert E. Shaum	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) lung infection (Pneumonia)		CAUSE OF DEATH (A) DUE TO lung infection (Pneumonia) (B) DUE TO obstructive lesion in the trachea (?) malignancy (C) hypertension		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-18-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes) or No yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-23-1967 to 7-19-1967 , that (I) (we) last saw the deceased alive on 7-18-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodolfo M. Lira		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-19-67	
23C. PHYSICIAN'S NAME (Type) Rodolfo M. Lira		23D. ADDRESS CHH			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 22, 1967		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Shaum		25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.	
				ADDRESS Baltimore Md.	

215-021188 John's Green
Apr. 4. 5. 1900 - 1900 - 1900 - 1900
215-021189 John's Green
Apr. 4. 5. 1900 - 1900 - 1900 - 1900

5-10 8-53

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-1621		67 6942		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6942	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) JOSHUA IRVIN JEFFRIES			
2. DATE AND HOUR OF DEATH				7-18-67 9 P.M. B			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
37 Mercy Hospital.				Md		26-01	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				21206			
D. STREET ADDRESS (If rural, give location)				4412 Forrest View Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
M.	W	never married	Sept. 18. 1908	58			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Salesman, Retired				Hagerstown, Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John H. Jeffries				Mary E. Cloman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
yes		W.W. II 086-01-7487		Mrs. Ellen B. Kettell		4210 Raymar Ave. Baltimore Md. 21206	
18. 743X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) massive aspiration			
ANTECEDENT CAUSES				(B) cerebrovascular accident			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) atherosclerotic hypertensive cardiovascular disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NONE				NO			
21A. ACCIDENT WAS OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
NONE							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8:45 PM July 18, 19 67 to July 18 19 67 , that (I) (we) last saw the deceased alive on 9:00 PM July 18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Scannon				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-19-67	
23C. PHYSICIAN'S NAME (Type) FERNANDO B. CANON				23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		July 21. 1967		Parkwood Cemetery		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 20 1967		Robert E. Faldy		HENRY SANDER & SONS, INC.		Baltimore Md.	

My dear Sir:

I have the pleasure to acknowledge the receipt of your letter of the 10th inst. regarding the matter of the ...

Very truly,
Yours,
J. H. ...

Very truly,
Yours,
J. H. ...

Very truly,
Yours,
J. H. ...

I am, Sir, very respectfully,
Yours,
J. H. ...

Very truly,
Yours,
J. H. ...

Very truly,
Yours,
J. H. ...

Very truly,
Yours,
J. H. ...

Very truly,
Yours,
J. H. ...

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-4001		67 6943		BALTIMORE CITY HEALTH DEPARTMENT		67 6943	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				Registered No.			
1. NAME OF DECEASED (Type or Print) Bertie Bailey (Bertha)				2. DATE AND HOUR OF DEATH July 17, 1967 7:20 p. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bolton Hill Conv. & Nursing Center				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore City			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1613 Westwood Avenue # 17			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4 - 14 - 98	9. AGE (in years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign county) Virginia, Accomack Co. U.S.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME HENRY KELLAM				14. MOTHER'S MAIDEN NAME MARY KELLAM			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Bolton Hill Nursing Center		ADDRESS 1400 John St.	
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/17/67 19 to 7/17/67 19, that (I) (we) last saw the deceased alive on 7/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i> M.D.				23B. DATE SIGNED 7/19/67			
23C. PHYSICIAN'S NAME (Type) HOLLIS DEUNARINE M.D.				23D. ADDRESS 5519 KENNISON AV BALD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-22-67		24C. NAME OF CEMETERY or CREMATORY Shiloh Bapt. Ch. Cem.		24D. LOCATION (City, town, or County) (State) Boston, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens	

James Thompson

4/10/12

4/10/12

4/10/12

at the

Stanger

and

Thompson

4/10/12

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Registered No. 67 6944

VS 150-REV. 1/1/65

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

I am sorry to hear that you are not satisfied with the result of the examination of the papers.

I have been very careful to examine the papers and to make a full and complete report.

I am sure that the result of the examination is correct and that the papers are in good order.

I am sure that you will be satisfied with the result of the examination.

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Name]

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Name]

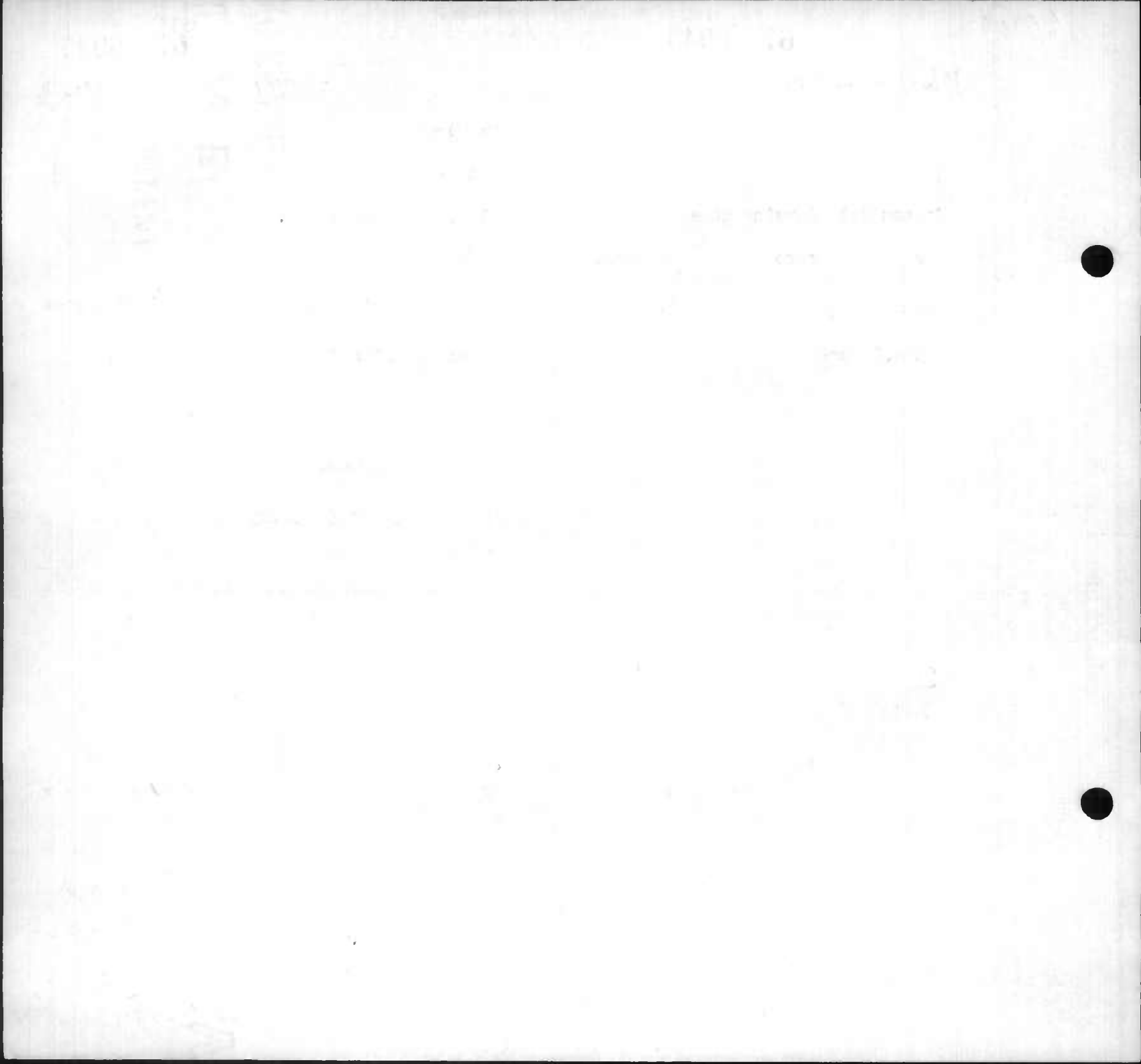
I am, Sir, very respectfully,
Your obedient servant,
J. H. [Name]

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Name]

FUNERAL DIRECTOR: IMPORTANT

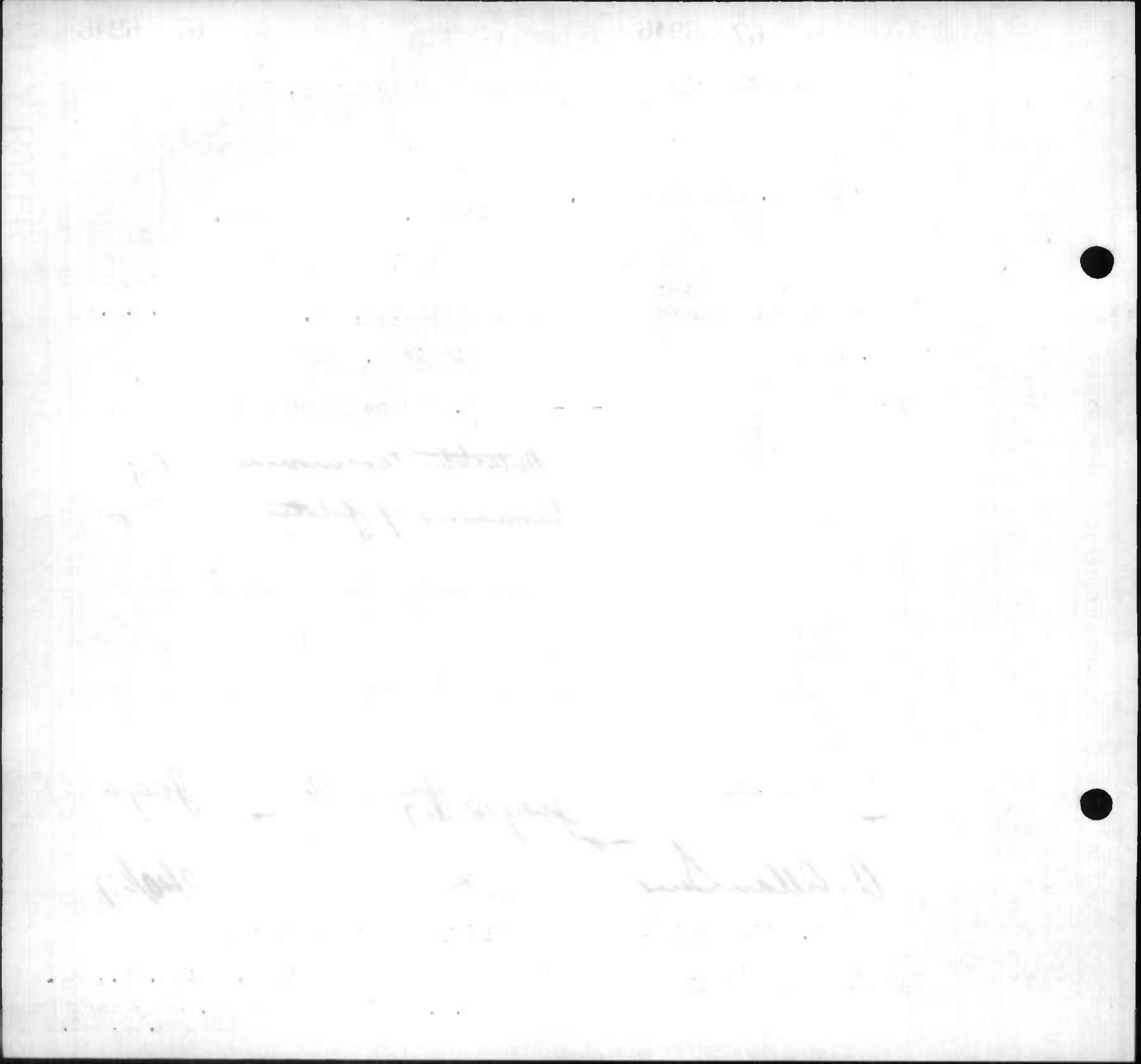
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 917	
BIRTH NO. 67 6945						67 6945	
M.E. CASE NO.							
1. NAME OF DECEASED <i>Robert John Eure</i>				2. DATE AND HOUR OF DEATH <i>7/18/67 12:30P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Bolton Hill Nursing Home</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>909</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>1303 N. Central Ave.</i>			
5. SEX <i>M</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>2/1/97</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>(R)</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>Samual Eure</i>				14. MOTHER'S MAIDEN NAME <i>Geneva Ballard</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <i>177X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Brain metastasis</i> DUE TO (B) <i>CA of prostate with metastasis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/11/67</i> to <i>7/18/67</i> that (I) (we) last saw the deceased alive on <i>7/18/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>ALLAN H. MACHT</i> M.D.				23B. DATE SIGNED <i>7/18/67</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>2E READ ST 21202</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>7/22/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>A. A. County. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 20 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Joseph B. Lockridge</i>		ADDRESS <i>1304 N. Central Ave</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

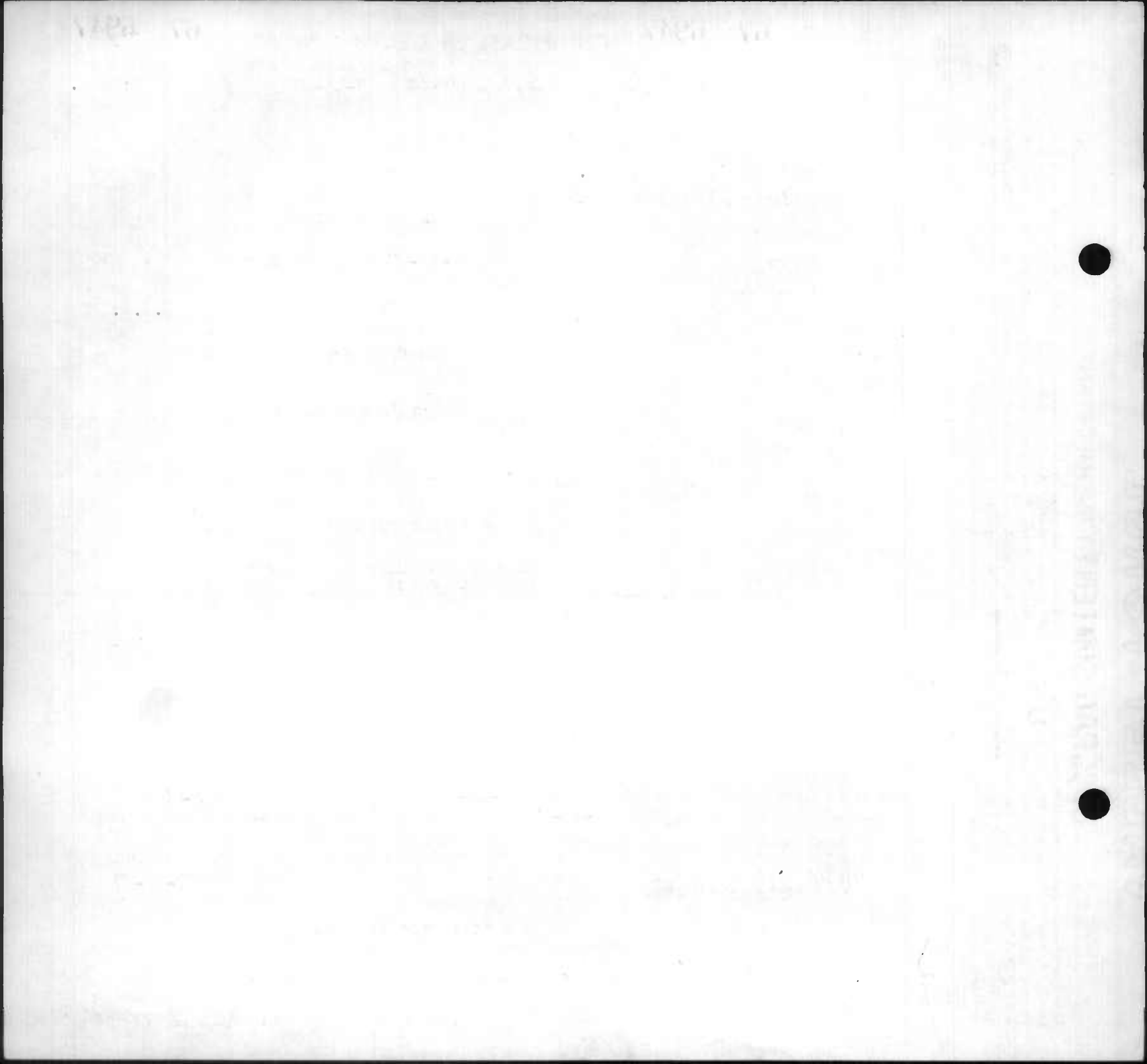
BIRTH NO. 67 6946				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6946	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Virginia Elizabeth Townshend				July 19, 1967 ^{100 P M.}			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 1324 E. Belvedere Ave.				A. STATE Maryland B. COUNTY 27-38			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1324 E. Belvedere Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/1/1907	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Educator-Retired			10B. KIND OF BUSINESS OR INDUSTRY Board of Education Baltimore, Md.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John C. Jett				14. MOTHER'S MAIDEN NAME Lizzie W. Bangs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-18-2885		17. INFORMANT M. Monroe Townshend		ADDRESS (Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic carcinoma				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Carcinoma of polate		2 yr	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 1966 to July 19 1967 , that (I) (was) last saw the deceased alive on July 18 1967 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.							
23A. SIGNATURE A. Allan Spier				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/20/67	
23C. PHYSICIAN'S NAME (Type) A. Allan Spier				23D. ADDRESS M.D. 1501 Pentridge Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/22/1967		24C. NAME of CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

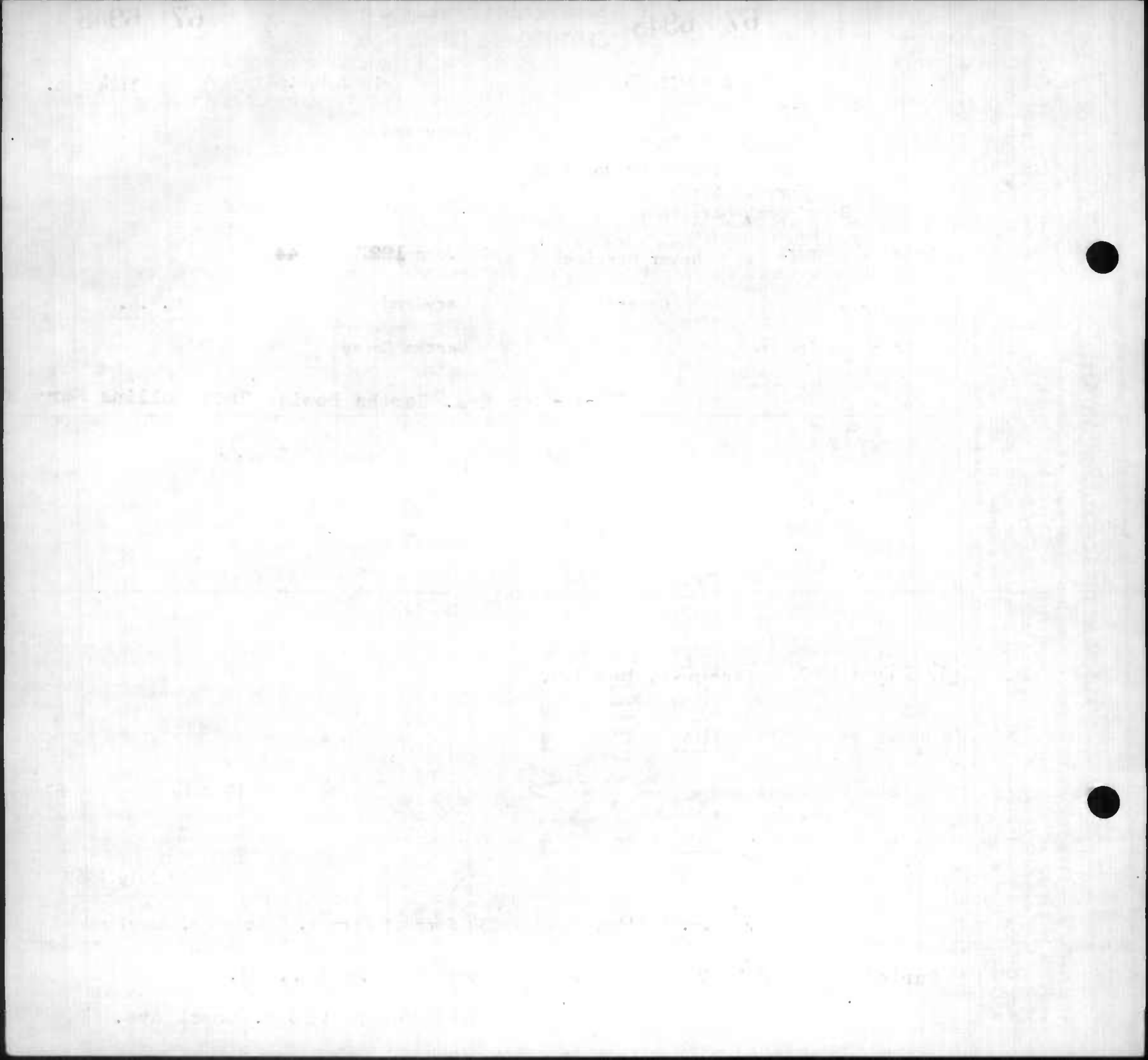
BIRTH NO. <u>67-13502 67 6947</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 6947 4</u>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>(Baby of Rita Neale) Rachel Sylvia Neale</u>			2. DATE AND HOUR OF DEATH <u>7-15-67</u> <u>5:20 A.</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>39 Provident Hospital, Inc.</u> <u>Baltimore, Maryland 21217</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-06</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2812 Baker Street</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>7-14-67</u>	9. AGE (In years last birthday) <u>Newborn</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>1 10</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Mr Joseph Neale</u>		
14. MOTHER'S MAIDEN NAME <u>Rita Carberry</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Mr & Mrs Joseph Neale</u>		
18. <u>25-4-31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) <u>Congenital Heart Disease</u> DUE TO (B) <u>Large interatrial septal defect</u> DUE TO (C) <u>Associated interventricular Septal defect</u> INTERVAL BETWEEN ONSET AND DEATH <u>Same</u>			19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-14-67</u> 19 to <u>7-15-67</u> 19, that (I) (we) last saw the deceased alive on <u>7-15-67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuel Mercado</u>				23B. DATE SIGNED <u>7-17-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Mercado</u>				23D. ADDRESS M.D. <u>1514 Division Street</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/19/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balto. Nat. Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 20 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Wm. C. March 928 E. North Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

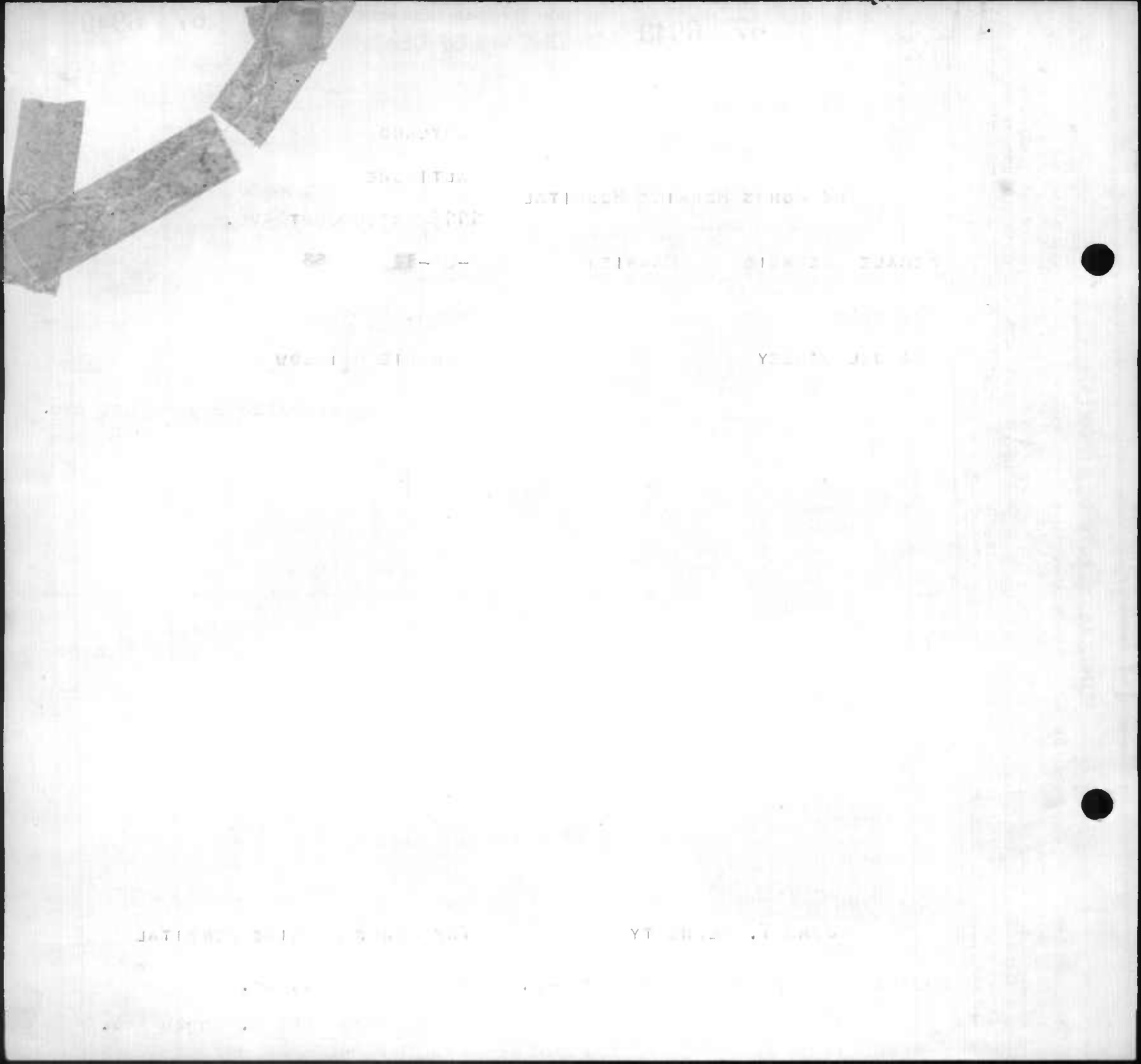
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6948	
CERTIFICATE OF DEATH											
BIRTH NO. 67 6948		M.E. CASE NO. M.									
1. NAME OF DECEASED (Type or Print) FRANK BOWIE Jr.						2. DATE AND HOUR OF DEATH 19 July 1967 3:24 p. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 92 Maryland Penitentiary Hospital 954 Forrest Street Baltimore, Maryland						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 25-33 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2504 Hollins Ferry Road					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 22 June 1923	9. AGE (In years, lost birthday) 44	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10B. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank Bowie Sr.						14. MOTHER'S MAIDEN NAME Bertha Casey					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-16-6148		17. INFORMANT ADDRESS Mrs. Bertha Bowie 2504 Hollins Ferry Rd					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH Metastatic Carcinoma of Brain DUE TO Squamous Cell Carcinoma of Left Lung (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
						II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5 June 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma, left lung				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 4/25 1967 to 19 July 1967 , that (I) (we) last saw the deceased alive on 3/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Henry M.D. Holljes						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 19 July 1967			
23C. PHYSICIAN'S NAME (Type) Henry M.D. Holljes						23D. ADDRESS M.D. 954 Forrest Street, Baltimore, Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/22/67		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6949		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6949	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) HUGHES, ADA V.			2. DATE AND HOUR OF DEATH July 18, 1967 1 25 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 10-81 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1115 GREENMOUNT AVE.		
5. SEX FEMALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-04-14	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Texas, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME SAMUEL DORSEY			14. MOTHER'S MAIDEN NAME CARRIE RAINBOW		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS William Hughes 1115 Greenmount Ave.		
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Cerebrovascular Accident DUE TO (B) Hypertension DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from July 13 1967 to July 18 1967 , that (1) (we) last saw the deceased alive on July 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John T. Flaherty			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 7/18/67	
23C. PHYSICIAN'S NAME (Type) JOHN T. FLAHERTY			23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/24/67	24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>67 6950</u>	
BIRTH NO. <u>67 6950</u>		M.E. CASE NO. <u>67 6950</u>						CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BERNETTA JONES</u>						2. DATE AND HOUR OF DEATH <u>7-18-67</u> <u>10:00 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 THE JOHNS HOPKINS HOSPITAL</u>						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1900 LAFAYETTE ST.</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>NEGROID</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3-16-14</u>	9. AGE (In years last birthday) <u>53</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pressure Operator Steel & Tin Products</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Balt. Md</u>			11. BIRTHPLACE (State or foreign country) <u>Balt. Md</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>ANDREW FLEET</u>			14. MOTHER'S MAIDEN NAME <u>LOTTIE HILL</u>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT <u>Robert Jones 1900 E. Lafayette Ave.</u>			ADDRESS		
18. <u>171X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of the</u> <u>Attenu Cervix</u>						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>? ~ 2-3 years</u>		
18. <u>II</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that this (this hospital) attended the deceased from <u>mid summer</u> 19 <u>66</u> to <u>7/18</u> 19 <u>67</u> , that (I) last saw the deceased alive on <u>7/18</u> 19 <u>67</u> and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.											
23A. SIGNATURE <u>Tim H. Parmely</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>7/18/67</u>		
23C. PHYSICIAN'S NAME (Type) <u>TIM H. PARMELY</u>						23D. ADDRESS M.D. <u>THE JOHNS HOPKINS HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>July 21/67</u>			24C. NAME of CEMETERY or CREMATORY <u>Carron Mem. Park</u>			24D. LOCATION (City, town, or county) (State) <u>Lanai Md</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 20 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>			25C. FUNERAL DIRECTOR <u>Milton E. Elckerson</u>			ADDRESS <u>1129 N. Carolina St</u>		

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Dr. H. A. Bond

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6951 CERTIFICATE OF DEATH					Registered No. 67 6951				
BIRTH NO. 67 6951					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) JOHN W. RAY					2. DATE AND HOUR OF DEATH 7/18/1967 5:25 pm M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					MARYLAND, BALTIMORE				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00				
					D. STREET ADDRESS (If rural, give location) 1031 DONNINGTON CIRCLE				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-31-10	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor			10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ROBERT RAY			14. MOTHER'S MAIDEN NAME AGNES WENKER						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-07-7943		17. INFORMANT ADDRESS Mrs. Mabel Ray 1031 Donnington Cir. 21204				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOGENIC CARCINOMA OF THE LUNG ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (it) (this hospital) attended the deceased from July 16 1967 to July 18 1967. That (it) (we) last saw the deceased alive on July 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (It) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John T. Flaherty					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/18/67		
23C. PHYSICIAN'S NAME (Type) JOHN T. FLAHERTY					23D. ADDRESS THE JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/21/67		24C. NAME OF CEMETERY or CREMATORY Bel-Air Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Bel-Air, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967			25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204				

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THE ABOVE IS A SUMMARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6952		BALTIMORE CITY HEALTH DEPT.		REGISTERED NO. 67 6952	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Marion F. Bush (Tom B. Patton)		2. DATE AND HOUR OF DEATH JULY 18, 1967 5:25 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME AND HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1908 ALICEANNA ST			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH April 13, 1897	9. AGE (In years last birthday) 70	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seaman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sunfish, Kentucky	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Martha	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11-1-16 10-30-20		16. SOCIAL SECURITY NO. 091-14-0124		17. INFORMANT Mrs Norma Hicks ADDRESS 2002 Fountain Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA		CAUSE OF DEATH (A) DUE TO PULMONARY EDEMA (B) DUE TO ARTERIOSCLEROTIC HEART DISEASE (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) _____	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/7 19 67 to 7/18 19 67 , that (I) (we) last saw the deceased alive on 7/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim Barzaga		23B. DATE SIGNED July 18, 1967		23C. PHYSICIAN'S NAME (Type) EPHRAIM BARZAGA HONORARIO JR	
23D. ADDRESS CHURCH HOME AND HOSP.		24. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7-20-1967		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6953		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6953	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Antoinette Fina		ANTOINETTE FINA		7-19-67 3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY			A. STATE Maryland B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 250 S. Exeter Street		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH May 18, 1894	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Peter Monaco			14. MOTHER'S MAIDEN NAME Columbina		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-03-7578	17. INFORMANT ADDRESS Mrs. Frances Trader 3108 Glenmore Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD ; diabetes ; hypertension			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 19 65 to July 19 67, that (1) (we) last saw the deceased alive on 7-19-67 and that in (my, (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A.E. WALSH				23B. DATE SIGNED 7-19-67	
23C. PHYSICIAN'S NAME (Type) A.E. WALSH				23D. ADDRESS 715 N. CHARLES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-22-1967		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			

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67 6954

BALTIMORE CITY HEALTH DEPARTMENT

67 6954

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) CHARLES L. EZZELL				2. DATE AND HOUR PRONOUNCED DEAD June 30, 1967 6:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2416 East North Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Virginia B. COUNTY Hampton C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soldiers Home D. STREET ADDRESS (If rural, give location)			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 11-27-11	9. AGE (In years last birthday) 56	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Ransom Ezzell				
14. MOTHER'S MAIDEN NAME Elizabeth Taylor			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT Tyndall funeral home Mount Olive N.C.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cause of death undetermined due to post mortem decomposition				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) DUE TO			
(B) DUE TO				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 19, 1967	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify) Removal		23B. DATE 7/19/67		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State) Mount Olive, North Carolina	
24A. DATE REC'D BY HEALTH DEPT. JUL 20 1967		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.		ADDRESS 1217 St. Paul St. Balto., Md. 21202	

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300 JOURNAL OF DOCUMENTATION

1997

Special Agent in Charge

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67 6955 CERTIFICATE OF DEATH

Registered No.

67 6955

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Steiger, Joseph Alphonsus

2. DATE AND HOUR OF DEATH

July, 16, 1967

5:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Maryland 212184. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3608 Old Frederick Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1/26/95

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bartender

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
United States

13. FATHER'S NAME

Carrol Steiger

14. MOTHER'S MAIDEN NAME

Apollenia

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

11/2/14-12/26/18

16. SOCIAL
SECURITY NO.

218-05-28-35

17. INFORMANT

Veterans Hospital Records
Baltimore, Maryland 21218

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) BRONCHOGENIC CARCINOMA
DUE TO(B) _____
DUE TO

(C) _____

6 Months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO.

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(X)~~ (this hospital) attended the deceased from July 5, 1967 to July 16, 1967,
that ~~(H)~~ (we) last saw the deceased alive on July 16, 1967 and that in ~~(H)~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~(H)~~ (We) (did) ~~(H)~~ (not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

July 17, 1967

23C. PHYSICIAN'S
NAME (Type)

JOSE RAMIREZ

M.D.

23D. ADDRESS

Veterans Administration Hospital, Balto., Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

July 20, 1967 Loudon National Cem.

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

Balto. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 20 1967

25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

G. Truman Schwab 3512 Frederick Ave. Balto. Md.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD

LINWOOD

BAKER

2. DATE AND HOUR PRONOUNCED DEAD

July 16, 1967

16:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

Wicomico Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Parsonsburg (Rural)

72-00

D. STREET ADDRESS (If rural, give location)

114 Fooks Street, Salisbury, Maryland

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 6, 1921

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lineman-Electrician

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Delmar, Delaware

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Linwood Baker

14. MOTHER'S MAIDEN NAME

Mattie Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL
SECURITY NO.
719-14-1561

17. INFORMANT ADDRESS

Mrs. Gladys M. Baker (Wife)
c/o Bohnak Trailer Park, Fruitland, Maryland

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral Injury and Subdural Hematoma

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

21D. TIME
OF INJURY
(APPROX.)

Unknown

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subject involved in a fight

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

7/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 19, 1967

23C. NAME OF CEMETERY or CREMATORY

Parsons Cemetery

23D. LOCATION

(City, town, or county)

Salisbury, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 20 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

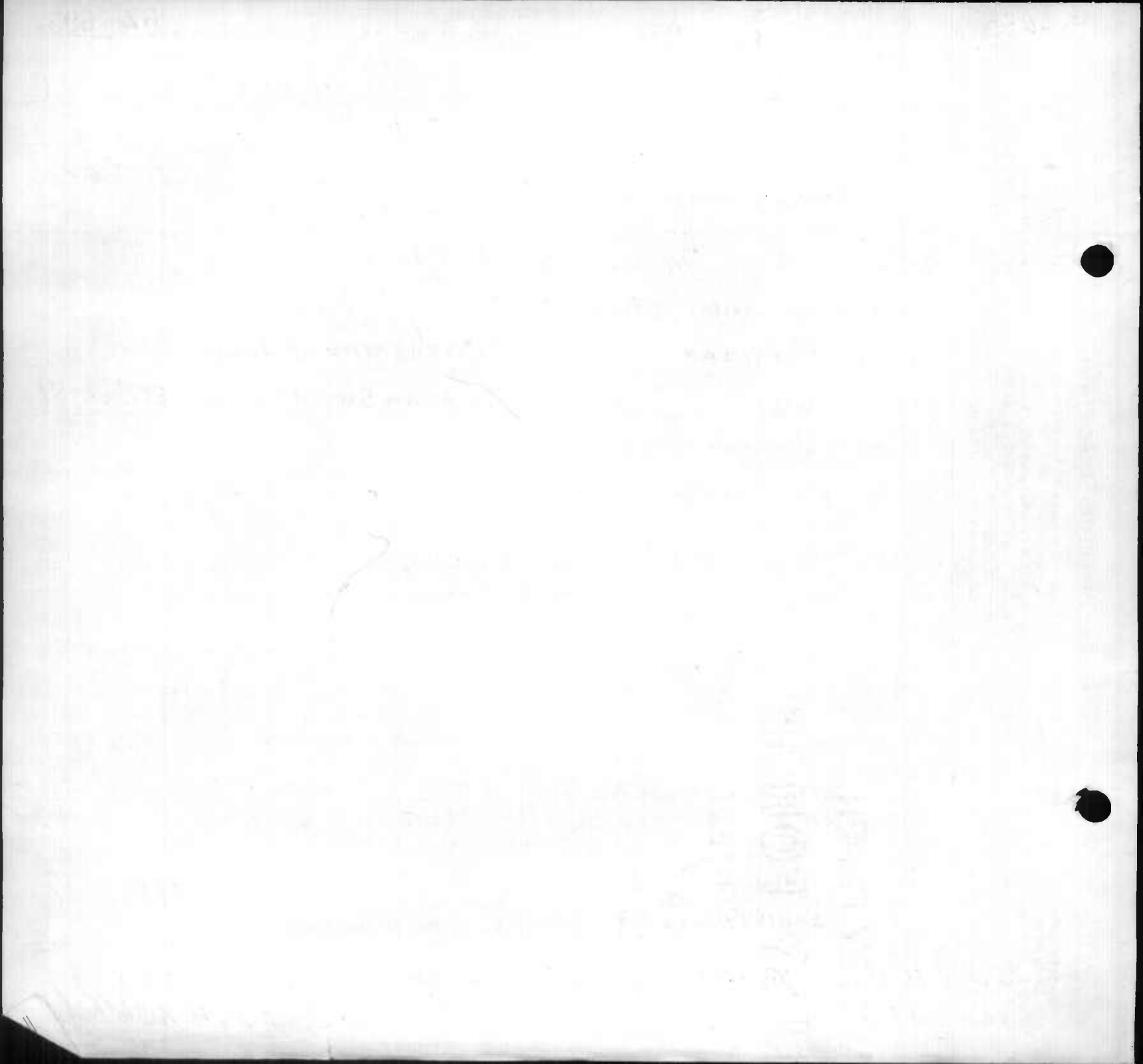
ADDRESS

HOLLOWAY & COMPANY, SALISBURY, MARYLAND

電話：88433333 傳真：88433333

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

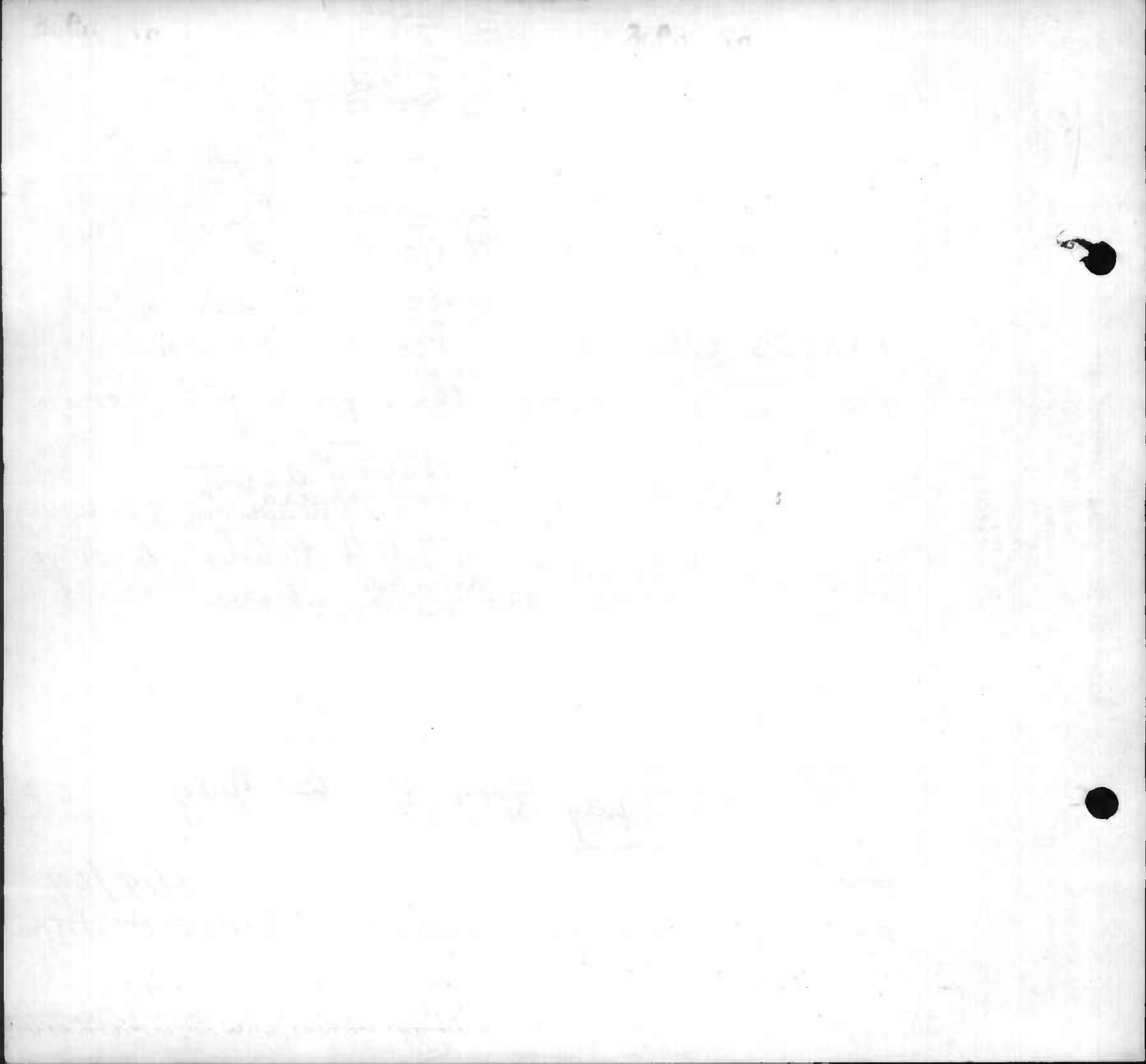
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6957	
67 6957 CERTIFICATE OF DEATH											
BIRTH NO.		67 6957									
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) Colin Sheridan						2. DATE AND HOUR OF DEATH 7/16/67 5:20 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1010 ST PAUL ST					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 8-17-1896		9. AGE (In years last birthday) 70		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LETTER CARRIER				10B. KIND OF BUSINESS OR INDUSTRY US Post Office				11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME LUKE SHERIDAN						14. MOTHER'S MAIDEN NAME CATHERINE EARLY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI				16. SOCIAL SECURITY NO.		17. INFORMANT DIANNA SHERIDAN				ADDRESS 1010 ST PAUL ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION 2 days						INTERVAL BETWEEN ONSET AND DEATH 2 days					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD yrs											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Old Myocardial Infarction											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 15, 1967 to July 16, 1967, that (I) (we) last saw the deceased alive on July 16, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Louis E. Grenzer						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/17/67			
23C. PHYSICIAN'S NAME (Type) LOUIS E. GRENZER						23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-19-67		24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL				24D. LOCATION (City, town, or county) (State) BALTIMORE Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 20 1967				25B. NAME OF REGISTRAR Robert E. J. J.				25C. FUNERAL DIRECTOR Frank J. Seitz 814 N 36th St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 6958		CERTIFICATE OF DEATH		Registered No. 67 6958	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				HERRINGTON, Beatrice		7/14/67 2:35 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL BALTO CITY, MD.				A. STATE MD B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE CITY 18-01			
5. SEX F				6. RACE Colored			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed				8. DATE OF BIRTH 1/29/24			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HW				11. BIRTHPLACE (State or foreign country) WASHINGTON D.C., USA			
13. FATHER'S NAME CHARLES WELDON				14. MOTHER'S MAIDEN NAME FLOSSIE BROWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT taken for hospital records				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Asphyxiation Hypoxemia Aspiration pneumonia 24 hours (B) DUE TO Uncontrolled diabetes mellitus 6 days (C) and Vulvar abscess			
INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 8 1967 to July 14 1967 that (I) (we) last saw the deceased alive on July 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Hector Feliciano M.D.				23B. DATE SIGNED 7/14/67			
23C. PHYSICIAN'S NAME (Type) HECTOR L. FELICIANO M.D.				23D. ADDRESS FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/20/67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Cedar Hill Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR A. D. B. E. J. D. M.		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3192 Schroeder St.	



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6960 CERTIFICATE OF DEATH					Registered No. 67 6960				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) KATHERINE BORTNER					2. DATE AND HOUR OF DEATH 7-14-67				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home					A. STATE Md. B. COUNTY 26-10				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21224				
					D. STREET ADDRESS (If rural, give location) 112 S. East Ave.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married		8. DATE OF BIRTH 2-2-1901	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Frank				14. MOTHER'S MAIDEN NAME Elizabeth Long					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Sadie Long			
						ADDRESS 111 S. Boydlin			
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic C. V. Disease					CAUSE OF DEATH (A) DUE TO Unknown				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 2/11/1950 to 7/14/1967 , that (I) was lost saw the deceased alive on 7/7/67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did not view the body after death.									
23A. SIGNATURE Henry J. Houska								23B. DATE SIGNED 7/14/67	
23C. PHYSICIAN'S NAME (Type) HENRY J. HOUSKA				23D. ADDRESS 333 S. EAST AVE BALTO MD 21224					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-17-67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Faldut			25C. FUNERAL DIRECTOR Thelma A. Hoffmann			ADDRESS 3218 Hudson	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6961				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6961	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILLIAM JOHN BOHLI				2. DATE AND HOUR OF DEATH July 18, 1967 10:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Convelesarium 7-27-67				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 D. STREET ADDRESS (If rural, give location) 146 Stevenson Lane			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 5, 1895	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claims Auditor			10B. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Ignatius Bohli				
14. MOTHER'S MAIDEN NAME Wilhelmina Chester Philomena Kircher			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I				
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Lawrence H. Taylor 131 Regester Ave. Dunkirk Rd.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 302.01 Acute hypostatic pneumonia Chronic bronchial asthma associated emphysema Chronic Myocarditis			CAUSE OF DEATH (A) DUE TO (B) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 48 hours	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 19 1967 to July 18 1967 , that (I) (we) last saw the deceased alive on July 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE H.V. Harbold				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 19, 1967	
23C. PHYSICIAN'S NAME (Type) DR. HAROLD V. HARBOLD				23D. ADDRESS 4706 Harford Rd. Baltimore, Md. 21244			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-21-67		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial		24D. LOCATION (City, town, or county) (State) Cockeysville, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Baltimore, Md. 21212	

THE BODY OF OLIVE COOK WAS RELEASED NO-MEDICAL EXAMINER'S CASE: DR. PALOMINO
MEDICAL EXAM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6962		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 6962	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		OLIVE COOK		7-15-67		1115 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY			
		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND					
33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE		10-01			
		D. STREET ADDRESS (If rural, give location)		1224 N. CENTRAL AVE.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
FEMALE	NEGROID	MARRIED	7-2 7-3-23	44					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
LABORER				MARYLAND		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
GEORGE MEEKINS		HELEN PHILLIPS							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				ARTHUR COOK		CAMBRIDGE, MD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) ENDOBRONCHIAL TUBERCULOSIS DUE TO		One year					
ANTECEDENT CAUSES		(B) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ACROMIOCLAVICULAR		XX TOOTHACHE					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		ALCOHOLISM		1 year					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 13, 1967 to July 15, 1967, that (I) (we) last saw the deceased alive on July 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/15/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
DAVID J. SHAW		M.D. JOHNS HOPKINS HOSPITAL, BALTIMORE							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
BURIAL		7/19/67		DORCHESTER LINAS ROAD		DOR. CO., MD.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 21 1967		Robert E. Farber		Frederick C. Deane		CAMBRIDGE, MD.			

1112 B

5-12-03

1112 B

1112 B

1112 B

1112 B

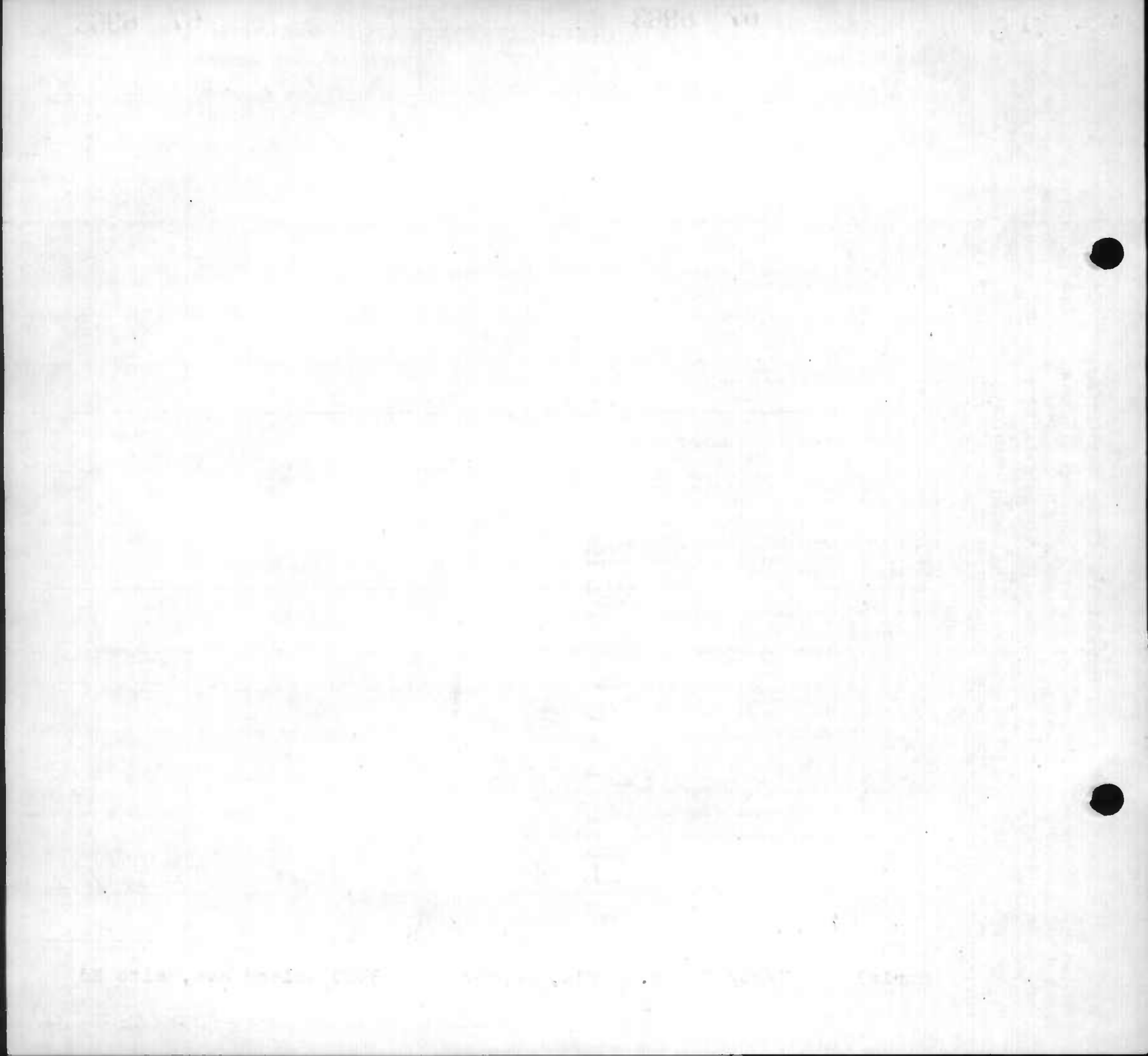
1112 B

1112 B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 6963 4	
BIRTH NO. 67-13916 67 6963				1. NAME OF DECEASED BABY GIRL DUNCAN		2. DATE AND HOUR OF DEATH 7/18/67 9 50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland 46				4. USUAL RESIDENCE (Where deceased lived; if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 20-05 D. STREET ADDRESS (If rural, give location) 2535 Ashton St. 21223			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 7/18/67	9. AGE (In years last birthday) —	If Under 1 Yr. Months: Days: Hours: Min. 0 0 0 34 min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME Billy Richard Duncan			14. MOTHER'S MAIDEN NAME Brenda Wright				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	17. INFORMANT Chart		ADDRESS		
18. 776X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) _____ DUE TO Immaturity (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 34 minutes	
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/18 1967 to 7/18 1967, that (I) (we) last saw the deceased alive on 7/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE F.S. Reroma				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/20/67	
23C. PHYSICIAN'S NAME (Type) F.S. REROMA				23D. ADDRESS M.O. LUTHERAN HOSP OF MD - BALTO, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/20/67		24C. NAME OF CEMETERY or CREMATORY St. Mary's, Hampden		24D. LOCATION (City, town, or county) (State) 3900 Roland Ave, Balto Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Austin E. Donovan		ADDRESS -3818 Roland Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6964		CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6964	
1. NAME OF DECEASED (Type or Print) Celia Keaton			2. DATE AND HOUR OF DEATH July 18, 1967 2⁰⁰ A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Balto City		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospt. Balto. Md 21201			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 18-03		
D. STREET ADDRESS (If rural, give location) 11 S. Arlington Ave #23					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/19/1907	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY At Home		
11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Anderson Dillon			14. MOTHER'S MAIDEN NAME Cora Presley		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 226-30-3860		
17. INFORMANT pts. Sister			ADDRESS above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11			CAUSE OF DEATH (A) myocardial infarction DUE TO 1/2 hr		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Thrombosis @ coronary artery DUE TO 1/2 hr		
			(C) Atherosclerosis of coronaries 10 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Severe Symptomatic Hemia Hiatus 5 years		
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) NO		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NO	
22. I certify that (I) (this hospital) attended the deceased from 5/25 19 67 to 18 July 19 67 , that (I) (we) last saw the deceased alive on 18 July 19 67 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis D. Drake				23B. DATE SIGNED 18 July '67	
23C. PHYSICIAN'S NAME (Type) Francis D. Drake				23D. ADDRESS UNIVERSITY HOSPT.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/22/67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem.	
24D. LOCATION (City, town, or county) (State) Glen Burnie Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR John J. Gowan & Son Inc.	
				ADDRESS 901 St. Hollins 23rd.	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6965

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PATRICIA KEITH (Patricia Eileen Keith)

2. DATE AND HOUR PRONOUNCED DEAD

July 19, 1967 7:27 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3167 X BEECHWOOD 2815 Hollins Ferry Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Feb. 4, 1943

9. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John E. Newman

14. MOTHER'S MAIDEN NAME

Helen Laisure

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-38-9243

17. INFORMANT

ADDRESS

Mr. John E. Newman 2815 Hollins Ferry Road

18. I
2817.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Key Highway and Clement Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

7 13 67 2:05 a.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto and fixed object

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 19, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/22/67

23C. NAME OF CEMETERY or CREMATORY

Loudon Park

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 21 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

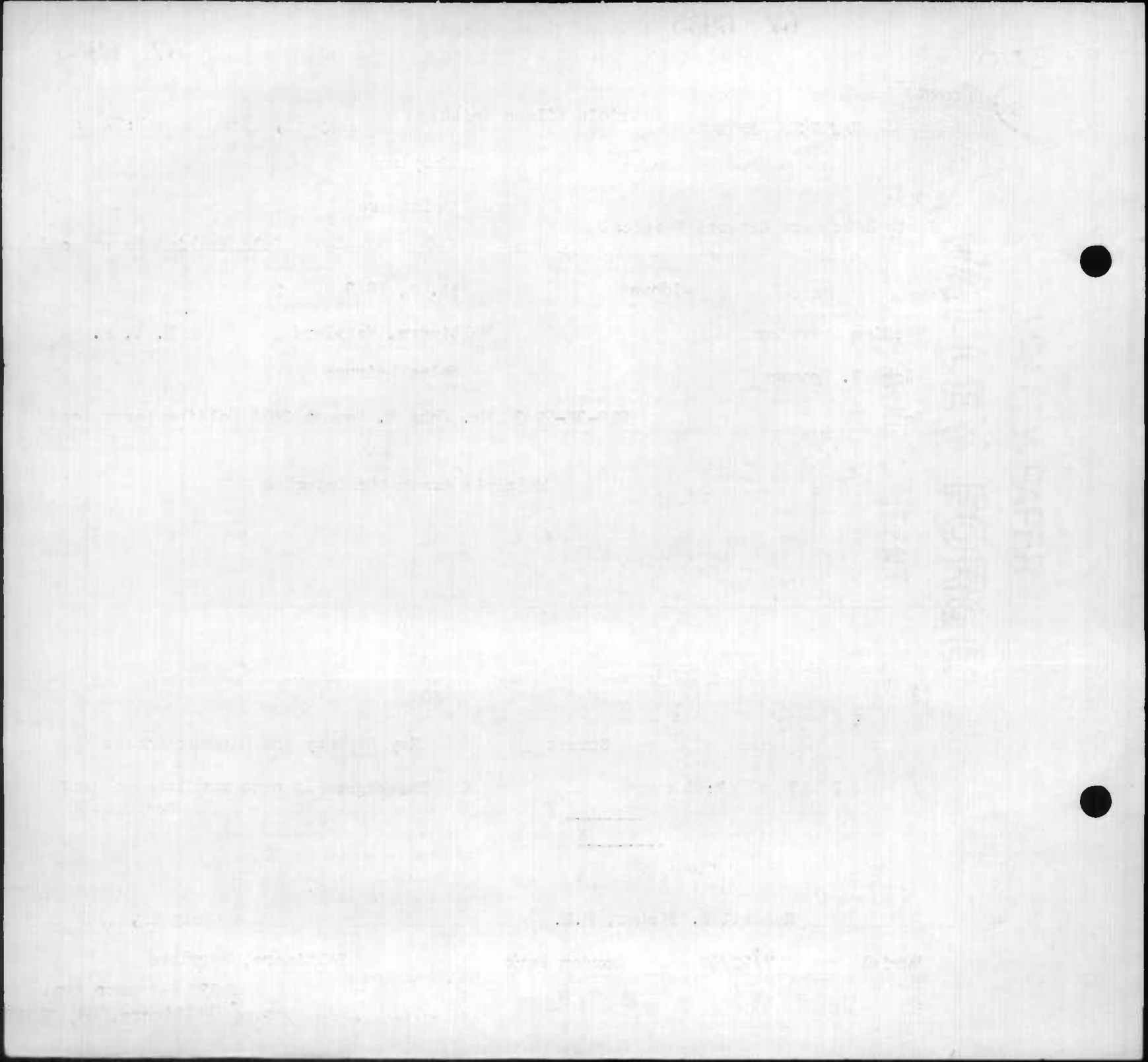
24C. FUNERAL DIRECTOR

McCully Funeral Home

ADDRESS

237 Patapsco Ave.

Baltimore, Md. 21225



1
K-520

67. 6966

BALTIMORE CITY HEALTH DEPARTMENT

67 6966

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

G.

ROBERT KING

2. DATE AND HOUR PRONOUNCED DEAD

July 19, 1967 8:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3449 Mayfield Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

Dec. 24, 1892

9. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ret- agent

10B. KIND OF BUSINESS OR INDUSTRY

Home Life Ins. Co.

11. BIRTHPLACE (State or foreign country)

Ellicott City, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph King

14. MOTHER'S MAIDEN NAME

Sadie Hilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

184-22-8119A

17. INFORMANT Address

Baldwin, Md.

Elmer King, son, Box 44, Fork Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular

DUE TO

Dis ease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 19, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/22/67

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

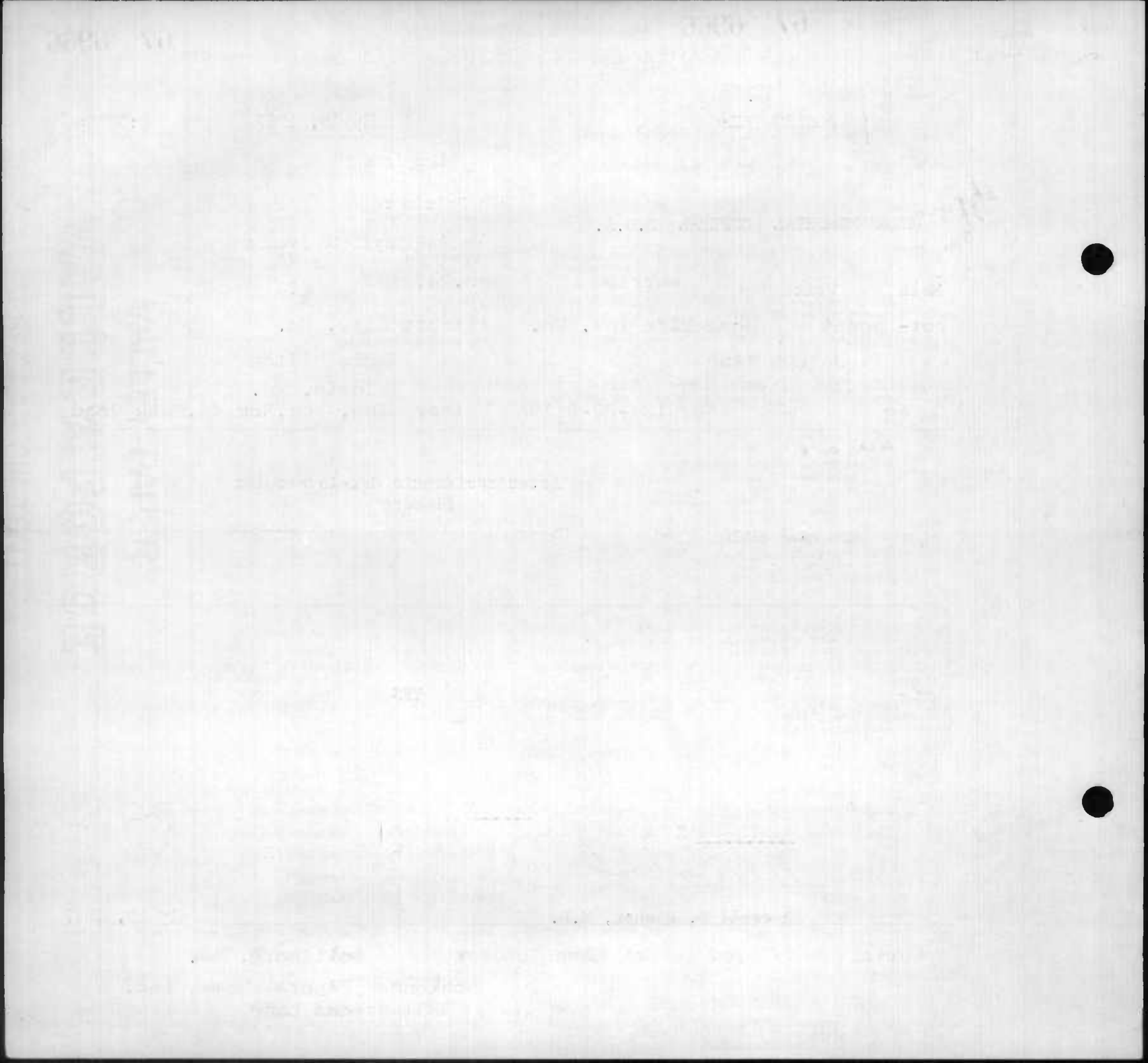
24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

3331 Brehms Lane

JUL 21 1967

Robert S. Fisher



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200		67 6967		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6967	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				MARY A. CAKE		7/18/67 2:25 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 635 NORTH LAKEWOOD AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 2-26-84	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JACOB ENGELBACH				14. MOTHER'S MAIDEN NAME MARYELLEN X SHEEHAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-07-6039		17. INFORMANT ADDRESS Margaret Cake, dght. above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cardiac arrhythmia DUE TO (B) Arteriosclerotic heart disease DUE TO (C) and perhaps digoxin toxicity		INTERVAL BETWEEN ONSET AND DEATH 6 weeks 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/12 1967 to 7/18 1967, that (I) (we) last saw the deceased alive on 7/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas C. Butler				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 18, 1967	
23C. PHYSICIAN'S NAME (Type) THOMAS C. BUTLER				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/22/67		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.			

MARK A. CAKE

THURSDAY 23rd

THE HONORABLE

THE HONORABLE

Guests

Cardiac embolism

Antemortem heart lesion 10 years

and perhaps slightly

None

No

Yes

72

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2118

2118

2118

2118

July 18, 1927

Thomas C. Butler

1
9-260

67 6968

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6968

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

P.

NICHOLAS QUIJARRO

2. DATE AND HOUR PRONOUNCED DEAD

July 18, 1967 6:58 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3119 Mareco Avenue

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3119 Mareco Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Nov. 11, 1898

9. AGE (in years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Navy

11. BIRTHPLACE (State or foreign country)

Cigayah, P. I.

12. CITIZEN OF
WHAT COUNTRY?

yes

13. FATHER'S NAME

Benito Quijarro

14. MOTHER'S MAIDEN NAME

Mary Pajar

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes-38 yrs - Navy

16. SOCIAL
SECURITY NO.

212-38-8395

17. INFORMANT

ADDRESS

Alma Lindemore Quijarro, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

NO

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

July 19, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/21/67

23C. NAME of CEMETERY or CREMATORY

Arlington Nat. Cem.

23D. LOCATION

(City, town, or county)

(State)

Arlington, Va.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 21 1967

Robert E. Fisher, M.D.

Schimunek Funeral Home, Inc.

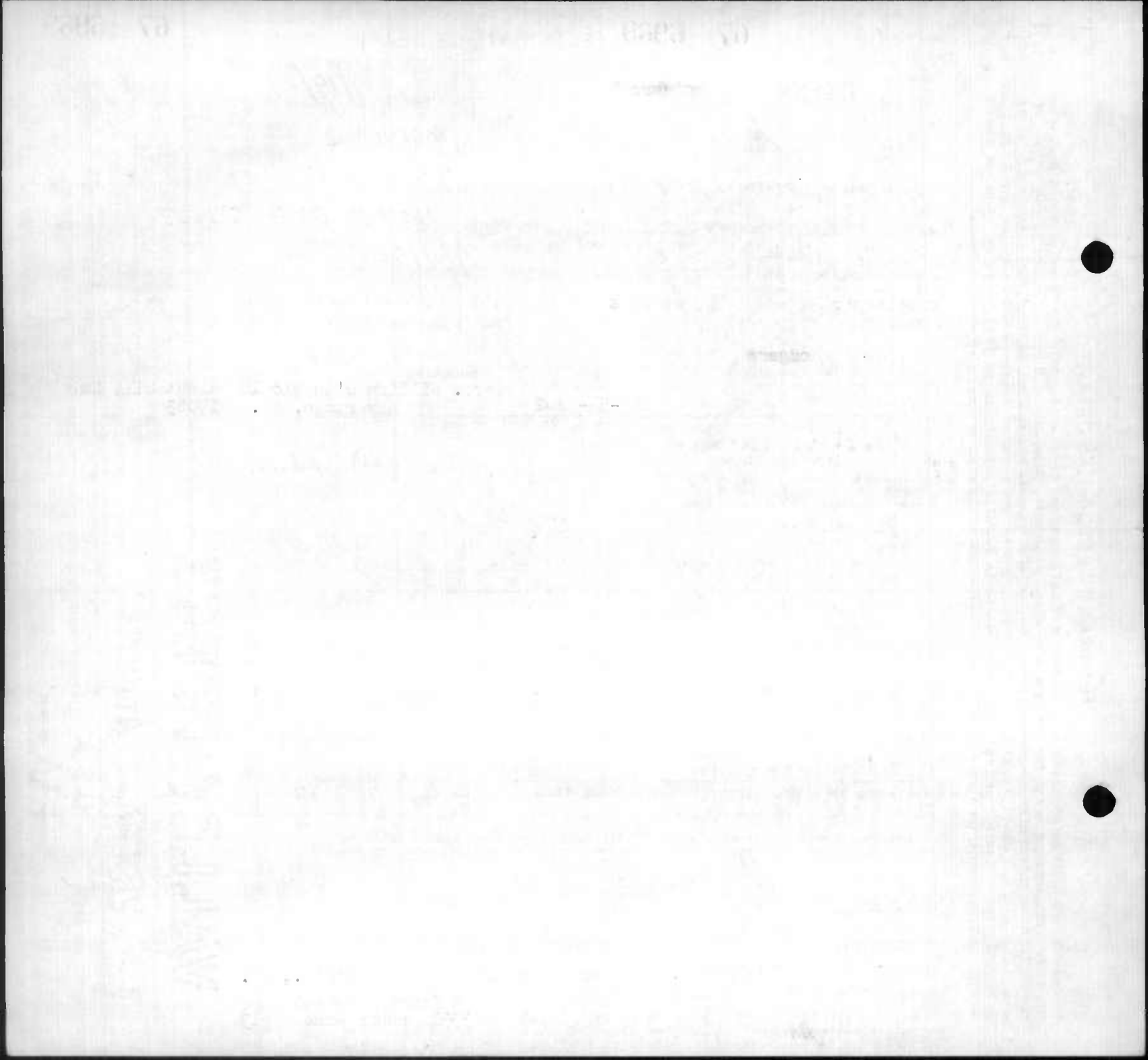
3331 Brehms Lane

WALTER P. BOWEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6969	
BIRTH NO. 67 6969				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		IRENE F. Rodgers		7/19/67 8:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Maryland General Hospital			MARYLAND		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
BALTIMORE			1607 E. 29th STREET		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
Female	White	Single	9/11/90	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housekeeper		at home		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN Rodgers			MARY DAVEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		218-54-2902		Mrs. William D'Angelo 10 Walnut Hill Lane Havertown, Pa. 19083	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		
II			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 17, 1967 to July 18, 1967, that (I) (we) last saw the deceased alive on July 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
R. H. Bard M.D.				7/19/67	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Richard H. Bard M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/22/67		Baltimore Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 21 1967		Robert E. Taylor		Schumaker Funeral Home 3331 Brehms Lane #13	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6970	
BIRTH NO. 67 6970		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) COLLINS, CHARLES HENRY		2. DATE AND HOUR OF DEATH 7/18/67 10:00 P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. STREET ADDRESS (If rural, give location) 657 GUTMAN AVENUE			
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/22/92	9. AGE (In years last birthday) 74	10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY <i>Brooklyn Gpts</i>		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME MOSES COLLINS		14. MOTHER'S MAIDEN NAME CLARA BROWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1/22/18-3/17/19		16. SOCIAL SECURITY NO. 218-22-62-83		17. INFORMANT HOSPITAL RECORDS V.A. HOSPITAL, BALTIMORE, MD. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) BRONCHOGENIC CARCINOMA WITH WIDESPREAD METASTASES.		CAUSE OF DEATH (A) BRONCHOGENIC CARCINOMA WITH WIDESPREAD METASTASES. (B) (C) INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from JUNE 14, 1967 to JULY 18, 1967 , that XX (we) last saw the deceased alive on JULY 18, 1967 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE <i>George W Gaffney</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. XX		23B. DATE SIGNED 7/19/67	
23C. PHYSICIAN'S NAME (Type) GEORGE W. GAFFNEY, M.D.		23D. ADDRESS V.A. HOSPITAL, BALTIMORE, MD. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/24/67		24C. NAME OF CEMETERY Balti. National	
24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave					
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Joseph H. Lock Jr. 1304 N. Central Ave</i>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-206

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6971	
BIRTH NO. 67 6971		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDITH BUSH		2. DATE AND HOUR OF DEATH 7/19/67 7:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 00 3908 Park Hgts Av. Baltimore, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 1512			
		D. STREET ADDRESS (If rural, give location) 3908 Park Hgts Av.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5/1/01	9. AGE (In years last birth) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Marys Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Bush		14. MOTHER'S MAIDEN NAME ? Butler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 245-34-9240		17. INFORMANT Harold Bush (son)	
		ADDRESS		same	
18. 200.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Lymphosarcoma		(A) DUE TO		approx 6 mos.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0 March 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Lymphosarcoma		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1967 to 7/19 1967 , that (I) was last saw the deceased alive on 7/19 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death.					
23A. SIGNATURE D. W. STEWART		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/19/67	
23C. PHYSICIAN'S NAME (Type) D. W. STEWART		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/24/67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION (City, town, or county) (State) D. D. County, Md					
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Joseph B. Locks	
		ADDRESS		1304 N. Central	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 67 6972	
BIRTH NO. 67 6972						CERTIFICATE OF DEATH	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) HARRIET OMAHUNDRO				2. DATE AND HOUR OF DEATH July 18, 1967 2³⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL BALTO. 16, MD.				A. STATE Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO			
				D. STREET ADDRESS (If rural, give location) 3709 W. BELVEDERE Ave			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) N.M.	8. DATE OF BIRTH 9-12-1882	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child's NURSE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. Md		
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME James T. Omohundro			14. MOTHER'S MAIDEN NAME Alice V. LOWRY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-14-4283		17. INFORMANT ADDRESS Mrs. Lillian ST JEAN 3709 W. Belvedere Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12¹⁵ pm July 18, 1967 to 2³⁰ pm July 18, 1967 , that (I) (we) lost saw the deceased alive on July 18, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Angel H. Roque M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 18, 1967	
23C. PHYSICIAN'S NAME (Type) ANGEL H. ROQUE M.D.				23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-21-67		24C. NAME OF CEMETERY or CREMATORY MT. OLIVET		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR T. B. Wippert		ADDRESS 1300 Eutaw Place	

July 13, 1952
HARRIS, CALIFORNIA

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L-2001

67 6973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 6973

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LEWIS SYLVAN S.

2. DATE AND HOUR OF DEATH

7/18/67

4:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

27-20

D. STREET ADDRESS (If rural, give location)

3319 OLYMPIA AVENUE

5. SEX

MALE

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH

8/7/08

9. AGE (In years last birthday)

58

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FUNERAL DIRECTOR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ALBERT

14. MOTHER'S MAIDEN NAME

MINNIE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOEL D. LEWIS 2412 FOREST GREEN RD

18. 7/20/67

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) PULMONARY EDEMA

INTERVAL BETWEEN ONSET AND DEATH

4 1/2 hours

(B) CARDIOGENIC SHOCK

4 1/2 "

(C) MYOCARDIAL INFARCTION

24 hours?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/18 1967 to 7/18 1967, that (I) (we) last saw the deceased alive on 7/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (He) (She) (It) (did not) view the body after death.

23A. SIGNATURE

Joseph Gimbel

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7/18/67

23C. PHYSICIAN'S NAME (Type)

JOSEPH S. GIMBEL

M.D.

23D. ADDRESS

Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/20/67

24C. NAME OF CEMETERY or CREMATORY

Arlington Cemetery

24D. LOCATION

Balto

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 21 1967

25B. NAME OF REGISTRAR

Robert S. Taylor, M.D.

25C. FUNERAL DIRECTOR

Sylvan S. Lewis & Son, INC. Garrison, Md

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

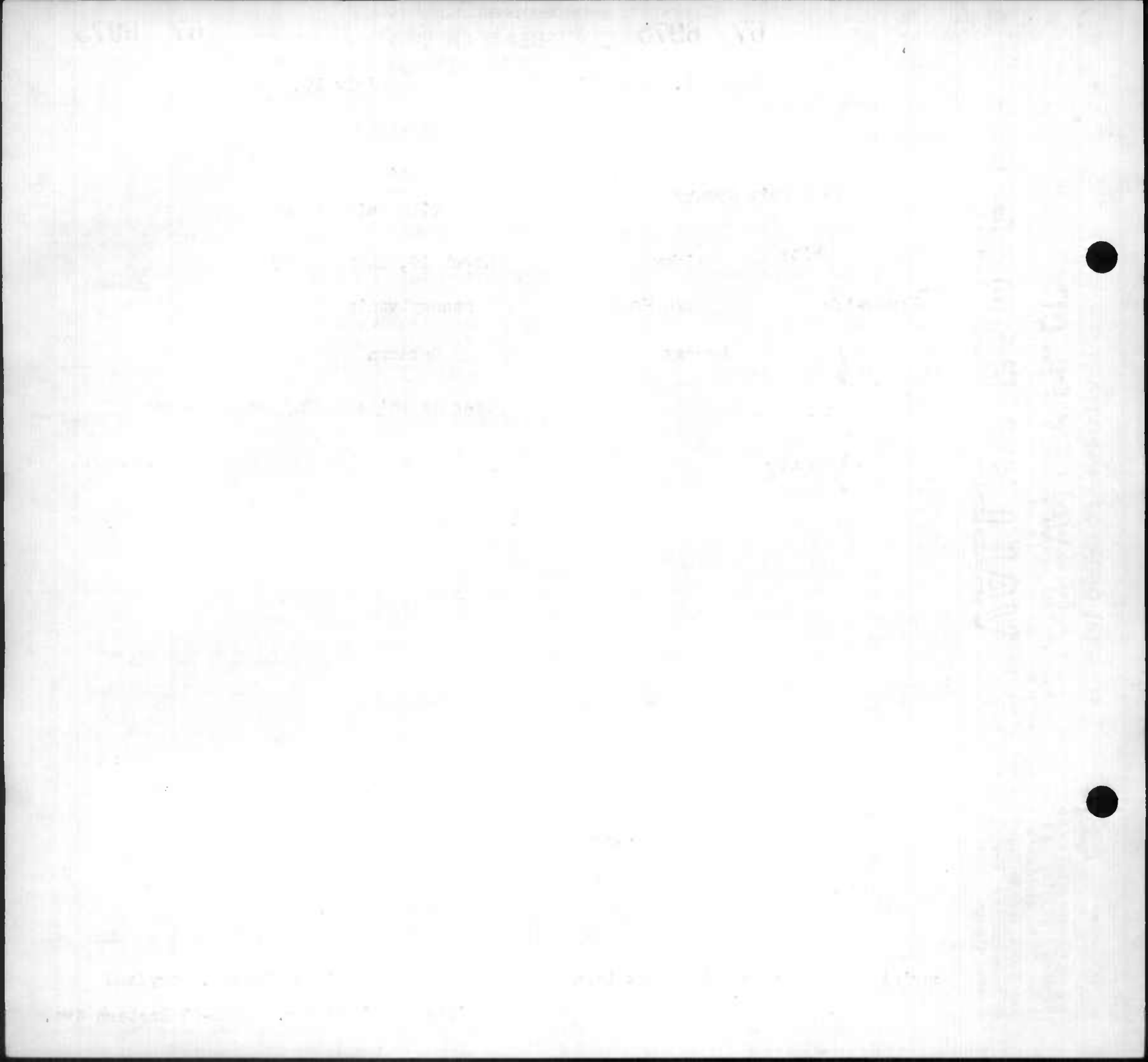
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 6974		67 6974	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Sadie Frances Simpson		2. DATE AND HOUR OF DEATH July 18, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		A. STATE B. COUNTY 216 N. Chester Street 31			
(If not in hospital or institution, give street address or location) 216 N. Chester Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md. 6-04			
		D. STREET ADDRESS (If rural, give location) 216 N. Chester Street 31			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Feb. 28, 1878	9. AGE (In years last birthday) 89	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----		10B. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Robert Bell		12. CITIZEN OF WHAT COUNTRY?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 220-46-3373		17. INFORMANT ADDRESS William Simpson 216 N. Chester Street 31	
18. 7-22-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Arterioscl. C.V. D's.</u> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> 19 <u>67</u> to <u>7-18-67</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-17-67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE <u>Bernie B. Moses, MD</u>		23B. DATE SIGNED 7-21-67		23C. PHYSICIAN'S NAME (Type) Bernie B. Moses, MD	
23D. ADDRESS 448 N. Luzerne Ave. Baltimore, Md.		23E. NAME OF REGISTRAR Philip S. Harris, Sons			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 22, 67		24C. NAME OF CEMETERY or CREMATORY Baltimore em.	
24D. LOCATION Baltimore d.		24E. ADDRESS 2024 Orleans St. 31			
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Philip S. Harris, Sons	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-530				BIRTH NO. 67 6975		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 6975	
1. NAME OF DECEASED (Type or Print) CLARA G. BENNETT						2. DATE AND HOUR OF DEATH July 19, 1967 M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2710 Fait Avenue						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
						D. STREET ADDRESS (If rural, give location) 2710 Fait Avenue					
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH March 20, 1894		9. AGE (In years last birthday) 73		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Murray						14. MOTHER'S MAIDEN NAME Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Charles White				ADDRESS 6303 Brook Avenue	
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular heart disease						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 30 min. 12 yr.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 24 Jan 1957 19 to 15 Jan 67 19, that (I) (we) last saw the deceased alive on 15 Jan 67 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
23A. SIGNATURE Dr. B. Bronushas						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 21 Jul 67	
23C. PHYSICIAN'S NAME (Type) JOSEPH B. BRONUSHAS, M. D.						23D. ADDRESS 3037 O'DONNELL STREET BALTIMORE 24, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-22-1967		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967				25B. NAME OF REGISTRAR Robert E. Tolson				25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

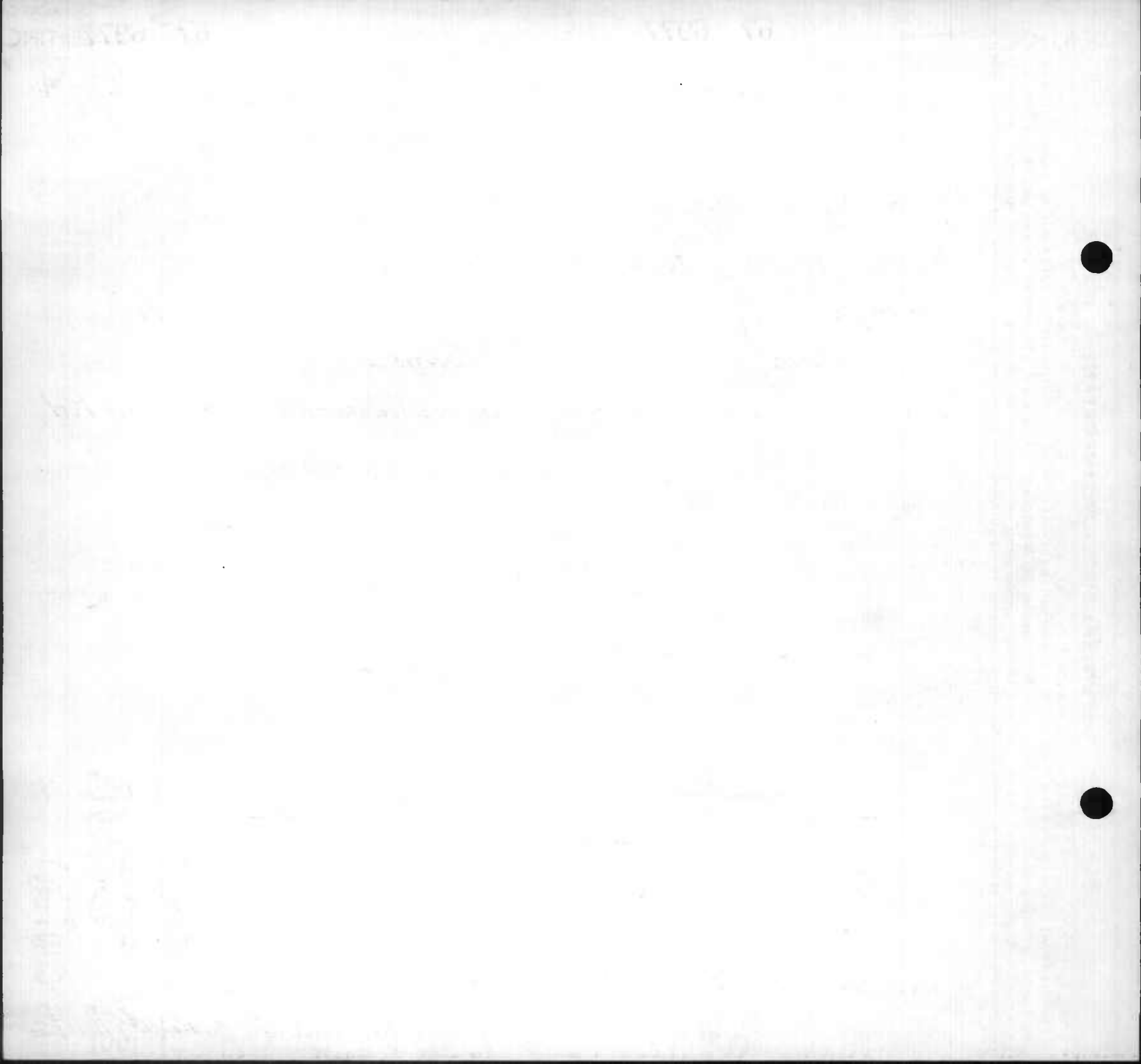
BIRTH NO. 67 6976				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6976	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Della Richardson				2. DATE AND HOUR OF DEATH 7-18-67		6:10 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing Home Baltimore, Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 822 Carrollton Avenue			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 4-12-80	9. AGE (In years last birthday) 87	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph				14. MOTHER'S MAIDEN NAME Barbara Holt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 104126307		17. INFORMANT Howe Young 1734 McCulloh Street		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) cerebro-vascular accident DUE TO (B) arteriosclerotic cerebro-vascular disease. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH several weeks several yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				decubitus ulcer back		several weeks.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-20-67 19 to 7-18-67 19, that (I) (we) last saw the deceased alive on 7-17-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Ellsworth Cook				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-19-67	
23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK				23D. ADDRESS M.D. 2431 MARYLAND AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-22-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Em. Park		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

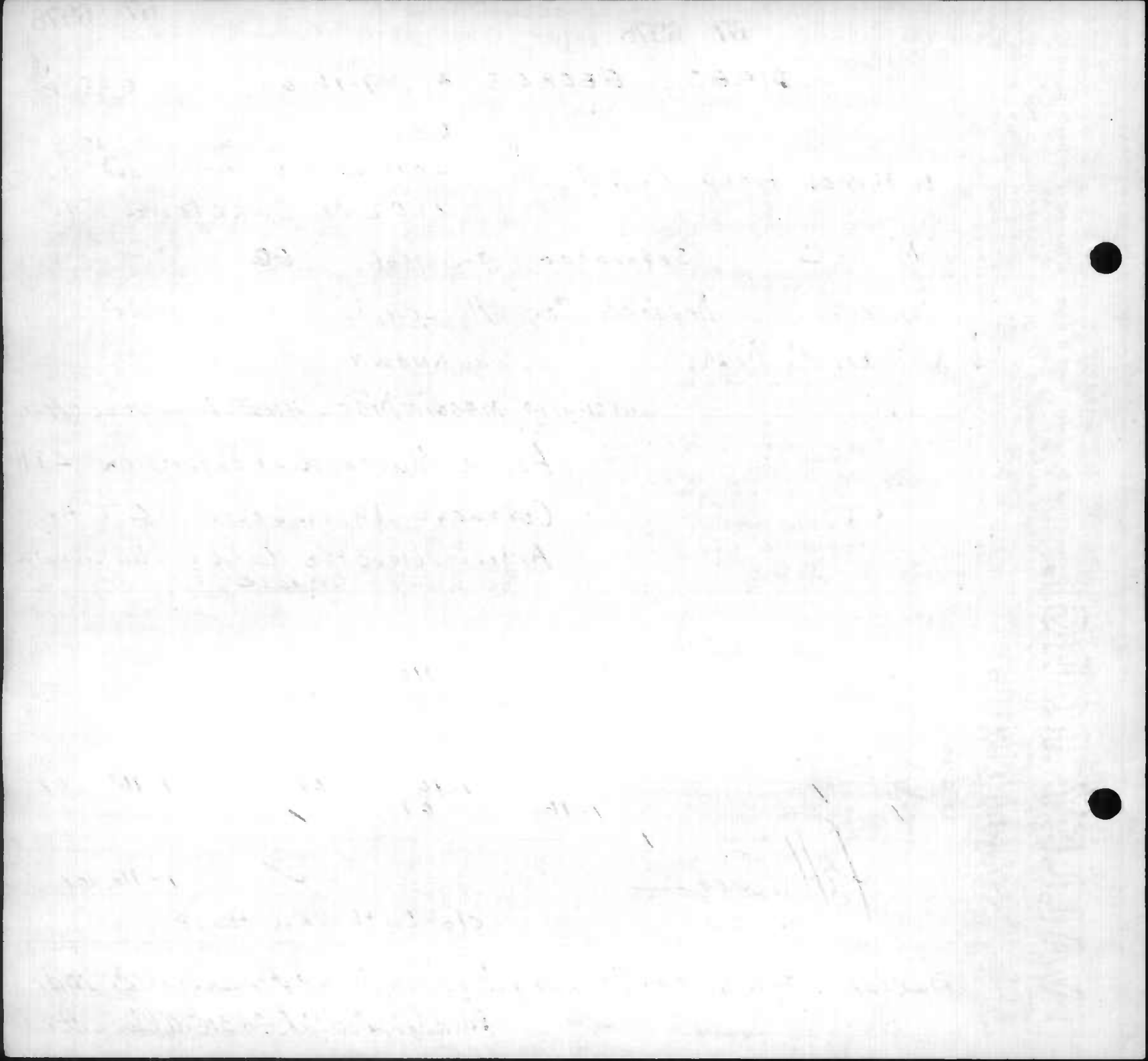
BIRTH NO. 67 6977				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6977	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				ROSINA CALDARARO		7-19-1967 10:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
90 GOULD CONVALESCARIUM				MARYLAND		28-41	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				5316 Liberty Heights Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days	11. If Under 24 Hrs. Hours: Min.	
Female	White	Widowed	9-1-1877	79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
At Home					Italy		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Auciello				Same			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No			None		Thomas Calder - 1208 Brandford Rd		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			19. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
II			Recurrent myocardial infarction 9 hours			9 hours	
ANTECEDENT CAUSES			DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO				
			Ventricular Fibrillation				
			Arteriosclerotic Cardio-Vascular disease				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 9 1967 to July 15 1967, that (I) (we) last saw the deceased alive on July 15 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
L.V. Harbold				July 21, 1967			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
H.V. HARBOLD				4706 Harford Road Baltimore Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-19-67		Lorraine Cemetery		Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 21 1967		Robert E. Fisher, M.D.		Ellsworth Armacost		4604 Liberty Heights	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

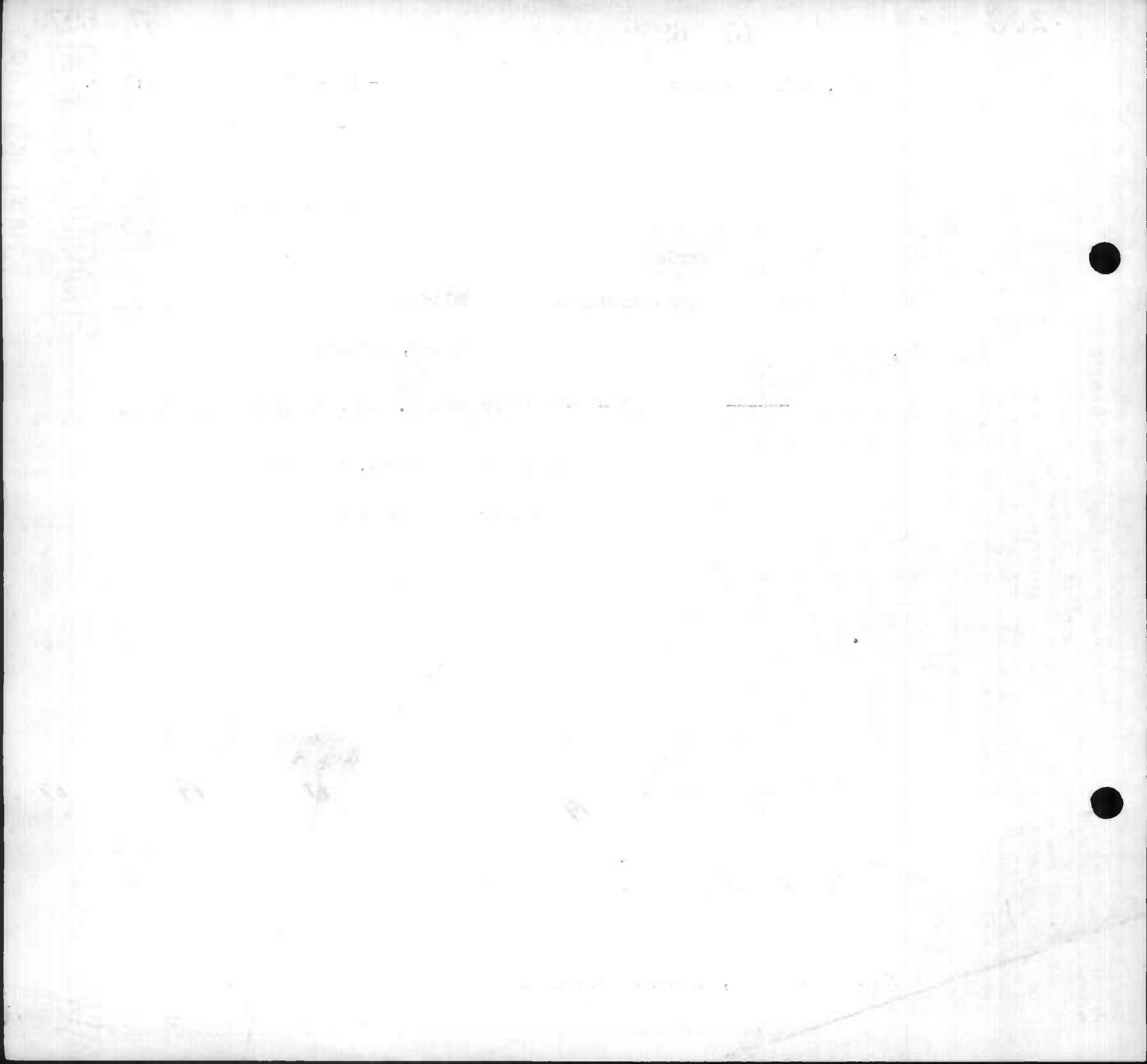
BALTIMORE CITY HEALTH DEPARTMENT									
67 6978 CERTIFICATE OF DEATH					Registered No. 67 6978				
BIRTH NO. 67 6978					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) DIGGS, GEORGE A.					2. DATE AND HOUR OF DEATH 7-16-67 6 25 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hosp of Md., Inc.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 16 15-47				
D. STREET ADDRESS (If rural, give location) 2102 N. Dukeland St.									
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 9-5-1906	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10B. KIND OF BUSINESS OR INDUSTRY Drydock Co.		11. BIRTHPLACE (State or foreign country) Hobson, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William H. Diggs			14. MOTHER'S MAIDEN NAME UNKNOWN						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-01-4113		17. INFORMANT ADDRESS Maggie Diggs 411 E. Lafayette Ave.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction < 1 Hr.					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Thrombosis < 1 Hr.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardio. Unknown Vascular Disease									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from 7-16 1967 to 7-16 1967 , that (2) (we) last saw the deceased alive on 7-16 1967 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. DUREZA					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-16-67		
23C. PHYSICIAN'S NAME (Type) R. DUREZA					23D. ADDRESS c/o Lutheran Hosp				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-21-67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR R. DUREZA		25C. FUNERAL DIRECTOR Randolph J. Collick		25D. ADDRESS 2431 E. Oliver St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6979				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6979	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Weis, Andrew Julius		2. DATE AND HOUR OF DEATH 7 - 19 - 67 7:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BOLTON HILL NURSING CENTER				A. STATE Maryland B. COUNTY Baltimore City			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 914 North Chester Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/3/93	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Salemen		10B. KIND OF BUSINESS OR INDUSTRY Bysenhardt Produce		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Weis, John				14. MOTHER'S MAIDEN NAME Fisher, Cecelia			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-32-7861A		17. INFORMANT ADDRESS Frances E. Weis 914 N Chester Street			
18. I 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Prostate carcinoma, advanced DUE TO Congestive heart failure DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-11 19 67 to 7-19 19 67 , that (I) (we) last saw the deceased alive on 7-19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Ellsworth Cook M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-20-67	
23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK				23D. ADDRESS 2431 MARYLAND AVENUE M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE July 24, 1967	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) 4430 Belair Road Md			
25A. DATE RECEIVED BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Pappel Brothers Inc. 1800 E Lombard St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6980	
BIRTH NO. 67 6980		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 7/19/67 7 P. M.			
1. NAME OF DECEASED Jessie Robinson		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY G.A.Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Millersville, Maryland D. STREET ADDRESS (If rural, give location) Box 199 Rt 301			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11/2/00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME Tommy Robinson William Alston		14. MOTHER'S MAIDEN NAME 7		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD=CHF		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Pulmonary Embolus		INTERVAL BETWEEN ONSET AND DEATH 7 years 12 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Electrolyte imbalance					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-8 19 67 to 7-19 19 67 , that (I) <u>(we)</u> last saw the deceased alive on 7-19 19 67 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-19-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. UNIVERSITY HOSP, BALT			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/24/67		24C. NAME of CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Fairburn	
25C. FUNERAL DIRECTOR Charles C Rice		ADDRESS 661 W Barre St			

0250 0250

0250 0250

UNIVERSITY HOSPITAL

1000 1000

1000 1000

1000 1000

1000 1000

ASCD:CHF

Polymyositis

Polymyositis
YES

1000 1000

1000 1000

1000 1000

1000 1000

UNIVERSITY HOSPITAL

67 6981

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6981

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HELEN

KLERK

2. DATE AND HOUR PRONOUNCED DEAD

July 20, 1967

10:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

916 E. Pratt Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

916 E. Pratt Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

12-24-1911

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

CLIFFORD

HARGISS

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213-54-4483

17. INFORMANT

ADDRESS

ELLEN BRYAN 2217 GOUGH ST.

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/21/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7/21/67

23C. NAME OF CEMETERY or CREMATORY

OAKLAWN

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE MD

24A. DATE REC'D BY HEALTH DEPT.

JUL 21 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

JOHN W. WEBER & SON INC.

401 S. CHESTER ST

1890

1890



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6982		CERTIFICATE OF DEATH		Registered No. 67 6982	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) PAUL Edward Chenowith, Sr.			
2. DATE AND HOUR OF DEATH 7-19-67 2:13 P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 21214 27-44			
D. STREET ADDRESS (If rural, give location) 5913 EDNA AVE				5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married			
8. DATE OF BIRTH 4-19-06				9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Const. Engineer	
11. BIRTHPLACE (State or foreign country) md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry Chenowith	
14. MOTHER'S MAIDEN NAME Roseanne Hoff Snyder				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-6557	
17. INFORMANT Mrs. Christina Chenowith				ADDRESS Same		18. CAUSE OF DEATH 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction, acute ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic coronary thrombosis W. K. Chen	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH		MEDICAL CERTIFICATION	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7-18-67 19 to 7-19-67 19 that (I) (we) last saw the deceased alive on 7-19-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Frank Palmizano M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23B. DATE SIGNED 7-19-67		23C. PHYSICIAN'S NAME (Type) FRANK PALMIZANO		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 7/24/67		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967	
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		VS 150-REV. 1/1/65	

THE UNIVERSITY OF CHICAGO

PAUL J. JACOBI

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6983		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.		67 6983	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) ELLA M. HIEBLER				2. DATE AND HOUR OF DEATH 7-20-67 5:10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore Co.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21234 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital				D. STREET ADDRESS (If rural, give location) 8705 EMGE RD.							
5. SEX F		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 11-22-92		9. AGE (In years lost birthday) 74		10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WILLIAM MYERS				14. MOTHER'S MAIDEN NAME MARY CLARK							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Lester N. Hiebler		ADDRESS (Same)			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Renal Failure INTERVAL BETWEEN ONSET AND DEATH hours				(A) DUE TO							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Pneumonia hours							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO Carcinoma of Breast ± probable metastases (not diagnosed by tissue biopsy) years							
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? —		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? —							
22. I certify that (I) (this hospital) attended the deceased from July 20 19 67 to July 20 19 67 , that (I) (we) last saw the deceased alive on July 20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.											
23A. SIGNATURE Jean M. Throne M.D.								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/20/67	
23C. PHYSICIAN'S NAME (Type) Jean M. Throne								23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/24/67		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto, Md. 21214					

Mary

1874

1875

1876

1877

1878

1879

X

1880

1881

w-300

67 6984

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6984

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN

W,

WADE

2. DATE AND HOUR PRONOUNCED DEAD

July 20, 1967

8:45 A, M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4405 Arabia Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4405 Arabia Avenue

27-02

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

Sept. 29, 1902

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Shaft, Md.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

James F. Wa de

14. MOTHER'S MAIDEN NAME

Dorothy E. Merrill

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-05-7961A

17. INFORMANT

ADDRESS

Mrs. Shirley Brown 4405 Arabia Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pulmonary Emphysema

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/20/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/24/67

23C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 21 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck Inc. 5305 Harford Rd. 21214

WILLIAM H. HARRIS

JAMES H. HARRIS

J. H. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6985
BIRTH NO. 67 6985		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHARLES C. SCHMIDT.		
2. DATE AND HOUR OF DEATH JULY 20, 1967 12:20 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balt. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21234 53-00 D. STREET ADDRESS (If rural, give location) 7848 BAGLEY COURT		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-22-04	9. AGE (In years lost birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Transfer Co.		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA.				
13. FATHER'S NAME WILLIAM SCHMIDT		14. MOTHER'S MAIDEN NAME ELIZABETH JUNG		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-3454		17. INFORMANT JANE GIBSON ADDRESS SAME AS DECEASED
18. 58171 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCT. 6 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CIRRHOSIS (HEPATIC) <i>P. C. Cipriani</i>		INTERVAL BETWEEN ONSET AND DEATH 6		
19A. DATE OF OPERATION 7/19/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RESPIRATORY ASSISTANCE		20A. AUTOPSY? (Yes or No) YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7/14/67 19 67 to 7/20 19 67 , that (I) (we) last saw the deceased alive on 7/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Enrique Cipriani</i> M.D.				23B. DATE SIGNED 7/20/67
23C. PHYSICIAN'S NAME (Type) DR ENRIQUE CIPRIANI		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/24/67	24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214

4-7-74

United States District Court
Southern District of New York

IN RE: [illegible]

Case No. [illegible]

Memorandum

Re: [illegible]

James J. Connelley
James J. Connelley

FILED IN U.S. DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

U.S. DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

1974 APR 11

U.S. DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6986				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 6986	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Grimaldi, Mariano		2. DATE AND HOUR OF DEATH 7/20/67 4:55 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY Balt.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 8125 Philadelphia Rd.	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		(If not in hospital or institution, give street address or location)		5. SEX M 6. RACE W 7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 5/30/95 9. AGE (In years last birthday) 72		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Domenico Grimaldi				14. MOTHER'S MAIDEN NAME Rose Fiorini					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Mrs. Maria D. Grimaldi		ADDRESS (Same)			
18. 465 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest				CAUSE OF DEATH (A) DUE TO Pulmonary embolus		INTERVAL BETWEEN ONSET AND DEATH ~ 8 hr.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic bronchitis				(B) DUE TO		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 20 19 67 to July 20 19 67 , that (I) (we) last saw the deceased alive on July 20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE J.S. Urbanetti				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/20/67			
23C. PHYSICIAN'S NAME (Type) J.S. Urbanetti		M.D.		23D. ADDRESS Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 7/24/67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Mausoleum		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md. 21214			

General, M...

John Robert...

Construction...

...

Mr. B...

8132...

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Caroline...

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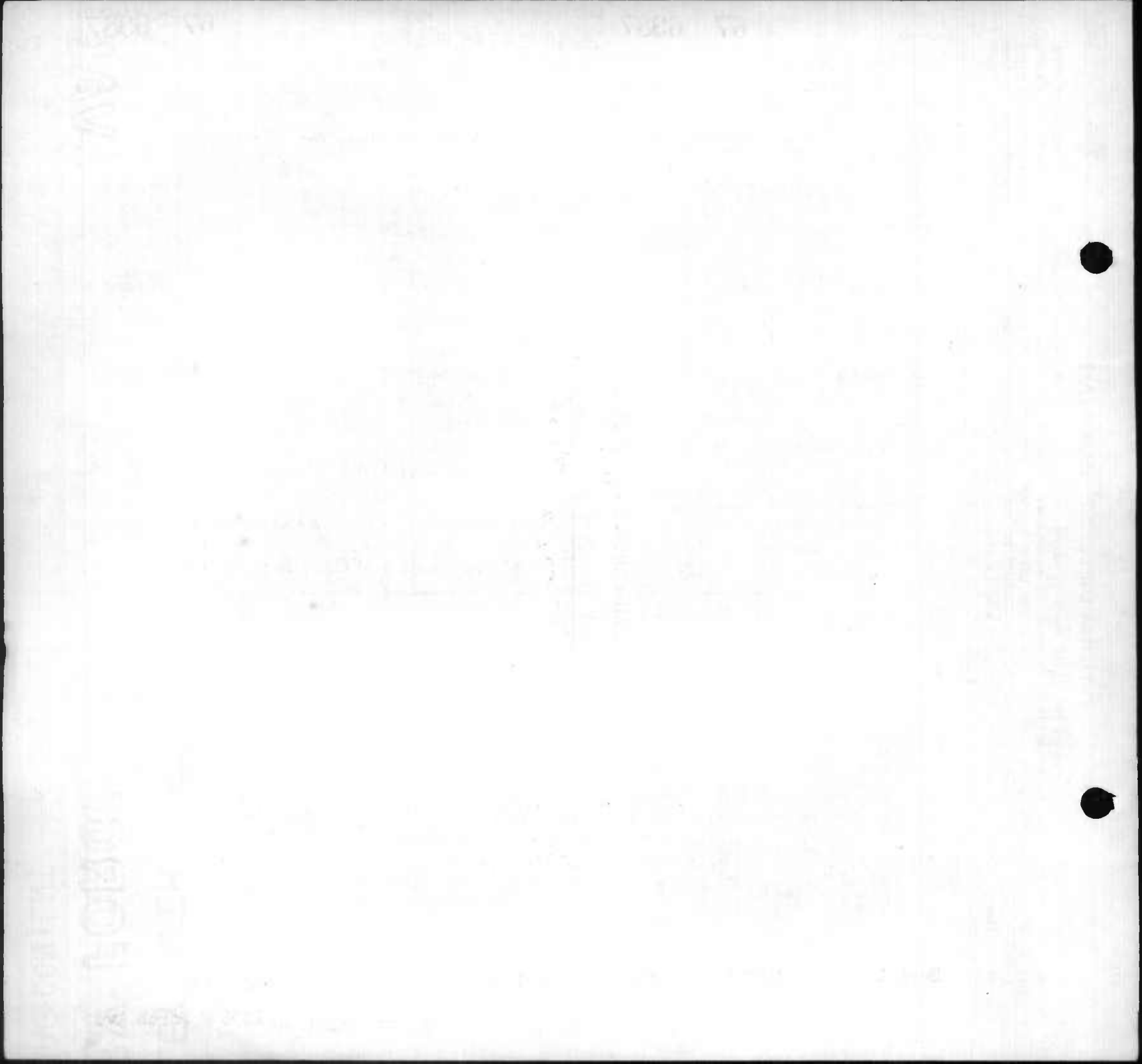
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6987	
BIRTH NO. 67 6987		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN HERRINGTON		2. DATE AND HOUR OF DEATH July 15, 1967 4:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital 38		A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md. D. STREET ADDRESS (If rural, give location) 17-01			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) ?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT Chart	
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Unknown CNS Disease		CAUSE OF DEATH Unknown CNS Disease		INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		MEDICAL EXAMINER CHIEF OR ASST. Edward J. Wiles		DUE TO existing status epilepticus and consequent CNS deterioration	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DUE TO Unknown			
19A. DATE OF OPERATION July 12, 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Probable Sub-Dural Hematoma		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Unknown		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) ?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ?	
22. I certify that (I) (this hospital) attended the deceased from July 8th 19 67 to July 15 19 67 , that (I) (we) last saw the deceased alive on 3⁰⁰ P.M. July 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.P. Stelich M.D.				23B. DATE SIGNED 7/15/67	
23C. PHYSICIAN'S NAME (Type) J.P. Stelich				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/22/67		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967			
25B. NAME OF REGISTRAR Robert E. Farber, MA		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6988

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RALPH W. LEIBY

2. DATE AND HOUR PRONOUNCED DEAD

July 16, 1967 11:40 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY KENT

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Betterton

D. STREET ADDRESS (If rural, give location)

Betterton, Maryland

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Dec. 9 - 1912

9. AGE (in years
last birthday)

54

11 Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MECHANIC

10B. KIND OF BUSINESS OR INDUSTRY

FARM MACHINERY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

EDWARD D. Leiby

14. MOTHER'S MARDEN NAME

GERTRUDE WHITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

218-05-1674

17. INFORMANT

ADDRESS

MRS. RALPH Leiby - Betterton MD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Craniocerebral injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Hotel

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Cellar Md. Hotel Betterton, MD.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

7 16 67 3:30 p

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject shot himself in face

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

JULY 20

23C. NAME OF CEMETERY or CREMATORY

STILL POND

23D. LOCATION

(City, town, or county)

(State)

STILL POND MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JUL 21 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Edgar L. Lane - Church Hill Md.

ADDRESS

THE BODY OF ARTHUR P. JESTER WAS RELEASED BY DOCTOR KORNBLUM OF THE MEDICAL EXAMINERS OFFICE. NON-FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6989	
BIRTH NO. 67 6989		CERTIFICATE OF DEATH		Registered No. 67 6989	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ARTHUR P. JESTER		2. DATE AND HOUR OF DEATH 7-18-67 11:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE MARYLAND B. COUNTY QUEEN ANN C	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CHESTER 21619 67-00		D. STREET ADDRESS (If rural, give location) X X	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-8-98	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED AUTOMOBILE DEALER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME EDWARD JESTER		14. MOTHER'S MAIDEN NAME ANNIE WALLS		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-30-1943		17. INFORMANT ADDRESS MRS. ARTHUR Jester - Chester	
18. 4-20-11-16-3X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) CARDIAC ARREST DUE TO (B) MYOCARDIAL INFARCTION DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH MD. 30 min.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		PULMONARY MALIGNANCY, RHEUMATIC HEART DISEASE			
19A. DATE OF OPERATION 7/18/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LESION ON X-RAY OF UNKNOWN ETIOLOGY		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/12/67 19 to 7/18/67 19 that (I) (we) last saw the deceased alive on 7/18/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Stephen H. Burnett M.D.		23B. DATE SIGNED 7/18/67	
23C. PHYSICIAN'S NAME (Type) STEPHEN H. BURNETT EDWARD STAFFORD		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 21		24C. NAME OF CEMETERY or CREMATORY CRUMPTON - MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS Edgard Lane - Church Hill, Md.	

50/50/5

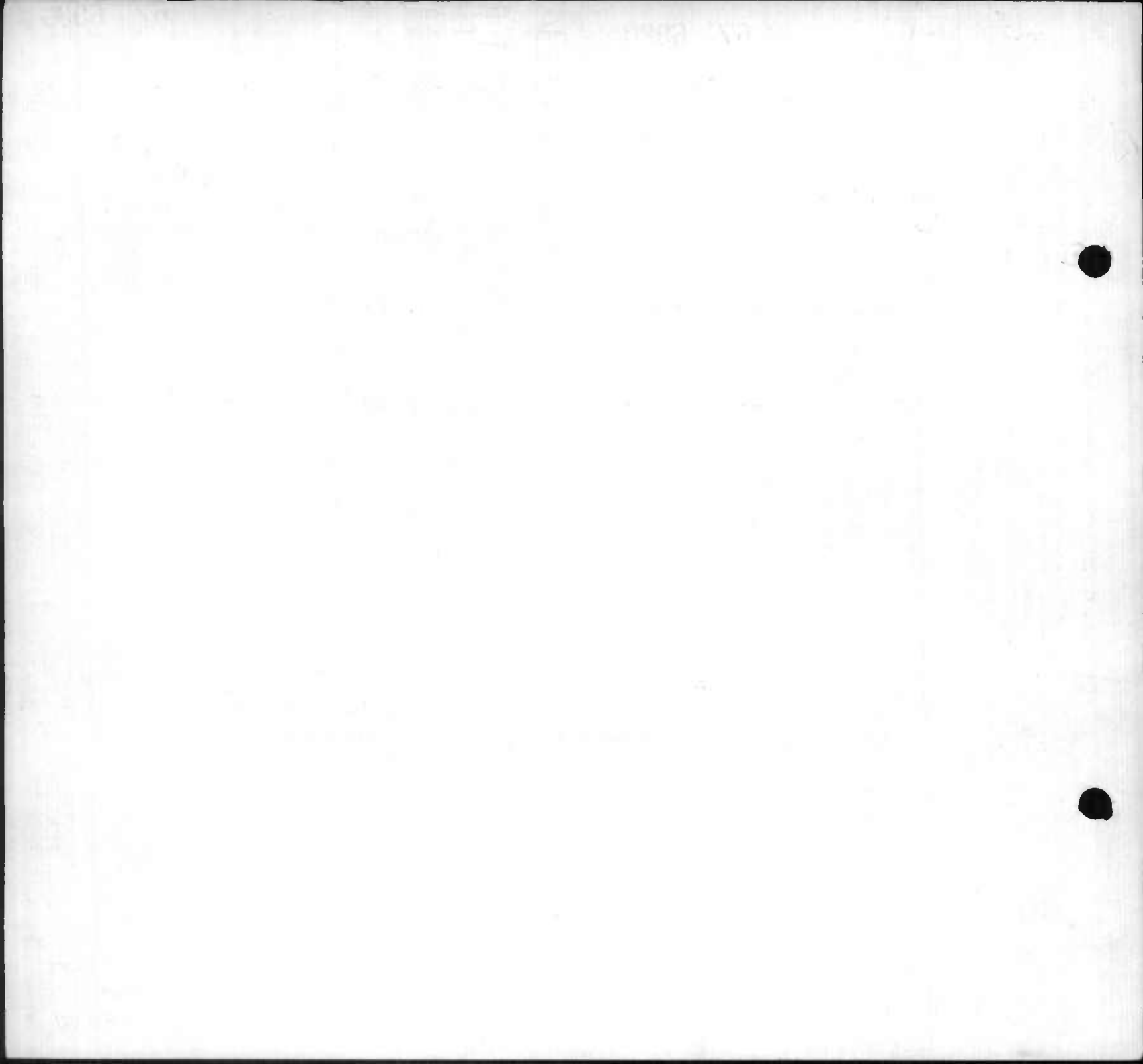
5/2/2017

5/15/03

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6990	
BIRTH NO. 67 6990		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>NICK DOLOMAN 415 OR DOLOERNUK</i>		2. DATE AND HOUR OF DEATH <i>7/21/67 2:38 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>35 CHURCH HOME AND HOSP</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>26-36</i>			
		D. STREET ADDRESS (If rural, give location) <i>6722 Youngstown Ave</i>			
5. SEX <i>M</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>3/13/87</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>COAL MINER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>26-36</i>		11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>NICK DOLOERNUK</i>		14. MOTHER'S MAIDEN NAME <i>UNK</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>187-03-2950</i>		17. INFORMANT <i>STEVE DENISUK</i>	
18. <i>420.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>ACUTE PULMONARY</i>		<i>1 DAY</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <i>ARTERIO-SCLEROTIC HEART DISEASE</i>		<i>CHRONIC</i>	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/13</i> 19 <i>67</i> to <i>7/21</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>7/21</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>S. Veneracion</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/21/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>VENERACION</i>		M.D. 23D. ADDRESS <i>CHURCH HOME & HOSP</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>JULY 24 67</i>		24C. NAME OF CEMETERY or CREMATORY <i>HOLY TRINITY CEM</i>	
24D. LOCATION (City, town, or county) <i>ELKRIDGE MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 21 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Tully</i>	
25C. FUNERAL DIRECTOR <i>DIPPEL BROS INC</i>		ADDRESS <i>1800 E LOMBARD ST</i>			



67 6991

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6991

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SELMA

V. CARTER

WATTS

2. DATE AND HOUR PRONOUNCED DEAD

July 15, 1967

11:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2439 Shirley Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2439 Shirley Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

July 2, 1926

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cashier

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas H. Dunaway

14. MOTHER'S MAIDEN NAME

Virginia Wise

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-24-8675

17. INFORMANT

James Watts

ADDRESS

714 Lennox Avenue

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

7/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-19-67

23C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Pk.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 21 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Arlington S. Phillips 1727 N. Monroe Street

ADDRESS

[Faint, illegible text, likely bleed-through from the reverse side of the page]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6992	
BIRTH NO. 67 6992		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Wilson, James E</i>		2. DATE AND HOUR OF DEATH <i>7-19-67 9:20 P</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University of Maryland Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>806 Tessier St.</i>	
5. SEX <i>M</i>	6. RACE <i>N</i>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>11/16/1900</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Davis Station, S.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Wilson</i>		14. MOTHER'S MAIDEN NAME <i>UNK.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>248-10-8874</i>		17. INFORMANT <i>Mrs. Ravenia Wilson</i> ADDRESS <i>806 Tissue St</i>	
18. <i>491X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>Hypotension, arrhythmia</i> (B) DUE TO <i>aspiration pneumonia</i> (C) DUE TO <i>Renal failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>7/13/67</i> <i>2 days</i>	
MEDICAL CERTIFICATION		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>GI bleeding</i>		Interval <i>1 month</i>	
		19A. DATE OF OPERATION <i>7/13/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>aspiration</i>	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/11 1967</i> to <i>7/19 1967</i> , that (I) (we) last saw the deceased alive on <i>7/19 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William A. Scovill M.D.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/19/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>William A. Scovill</i>		23D. ADDRESS M.D. <i>University of Maryland Hospital</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-23-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Walker Cemetery</i>	
24D. LOCATION <i>Sumpter</i>		24E. (City, town, or county) <i>S.C.</i>		24F. (State) <i>S.C.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 21 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Morton & Dyett F.H.</i> ADDRESS <i>1701 LAURENS</i>	

1950

John Wilson
Construction
P.O. Box 200

some receipts from Wilson for 1950

John Wilson Construction
P.O. Box 200

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 6993

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JACQUELINE WILLIAMS

2. DATE AND HOUR OF DEATH

7-19-67 11⁴⁵ A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

38 UNIVERSITY HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1119 McKean Ave, Balt. Md

5. SEX

Female

6. RACE

C

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

11-24-51 15

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balt. Maryland.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Williams

14. MOTHER'S MAIDEN NAME

Rebecca Manigault

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Joseph Williams 1119 McKean Ave

18. 241X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Airway Obstruction
DUE TO(B) Status Asthmaticus 13 hours
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

? Pneumothorax

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from 7-18 1967 to 7-19 1967,
that (I) (we) last saw the deceased alive on 7-19 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

BA Portnoy

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7-19-67

23C. PHYSICIAN'S
NAME (Type)

BA PORTNOY

M.D.

23D. ADDRESS

UNIVERSITY HOSP

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial 7-23-67

Arbutus Mem. Park. Arbutus

Md.

25A. DATE REC'D. BY HEALTH DEPT.

JUL 21 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Morton C. Dyck F.H.

ADDRESS

1761 LAURENS

JACQUELINE

UNIVERSITY HOSP
1114 McKean Ave, Balt. 16
FORM C

Airway Obstruction
Status: Asymptomatic 13 years

? Pneumothorax

BA Portney
University Hosp

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-2318		67 6994		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6994	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				<i>Boston, Steven</i>		<i>7/20/67 12³⁰ P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
<i>George Washington Nursing Home 607 PENNSYLVANIA AVE, Zone 1</i>				<i>Md. Baltimore city</i>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
<i>Baltimore</i>				<i>636 N. Carey St. 16-02</i>			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
<i>male</i>		<i>Negro</i>		<i>NEVER MARRIED</i>		<i>2/18/05 61</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
<i>Labour</i>				<i>Lowcester, VA</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Henry Boston</i>				<i>Louie Patterson</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<i>No</i>				<i>217-0304</i>		<i>Casper Boston - 636 N. Carey St</i>	
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
<i>Asperger's C.Y. Disease</i>				<i>Pneumonia</i>			
<i>See Anemia</i>				<i>See Anemia</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>0</i>		<i>0</i>		<i>No</i>		<i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<i>No</i>				<i>No</i>		<i>No</i>	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
<i>(Month) (Day) (Year) (Hour)</i>		<i>While At Work</i>		<i>Not While At Work</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>June 18, 1965</i> to <i>July 19, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
<i>M. L. Weara</i>				<i>1944 Drind Hill Ave</i>		<i>7-20-67</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>7/23/67</i>		<i>Mt Calvary</i>		<i>Brooklyn AA Co Md</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<i>JUL 21 1967</i>		<i>Robert E. Taylor</i>		<i>Durnell S. Oden</i>		<i>Balto. Md.</i>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6995	
BIRTH NO. 67-13930		67 6995		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) OLES BABY BOY			
2. DATE AND HOUR OF DEATH 07-17-67 12:30 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balt. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1209 DANIELS AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 7-17-67	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 4 17
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME THOMAS		14. MOTHER'S MAIDEN NAME MILDRED POLANCO			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES HOSPITAL - CATON & WILKENS	
18. 776X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Prematurity DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) this hospital attended the deceased from JULY 17 1967 to JULY 17 1967 . that (I) we last saw the deceased alive on JULY 17-67 19 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joyce M. Boyd				23B. DATE SIGNED 7-17-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. CATON & WILKENS AVES., BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/19/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Witzke F. D. - 4101 Edmondson Av.	

DATE: 11-11-61

TO: SAC, NEW YORK

FROM: SAC, BALTIMORE

SUBJECT: MURDER OF MARTIN LUTHER KING, JR.

RE: BALTIMORE TELETYPE TO NEW YORK, 11-10-61.

ENCLOSED FOR THE NEW YORK OFFICE ARE TWO COPIES OF A LETTERHEAD MEMORANDUM DATED AND CAPTIONED AS ABOVE.

VERY TRULY YOURS,

W. A. RICHARDS, JR., Special Agent in Charge

11-11-61

11-11-61

11-11-61

11-11-61

ORIGINAL FILED IN NEW YORK OFFICE

11-11-61

11-11-61

11-11-61

11-11-61

11-11-61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6996		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 6996	
M.E. CASE NO.						2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) EMMA J. SCOTTEN						July 18, 1967 8 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium 6116 Belair Road						A. STATE Maryland			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
						D. STREET ADDRESS (If rural, give location) 5126 Harford Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Sept. 29, 1887	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cardiff, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hugh W. Jones				14. MOTHER'S MAIDEN NAME Margaret Kirk					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS J. Ralph Scotten, 5126 Harford Rd. Baltimore, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I Arteriosclerotic C-V disease 3 years Cerebral degeneration Associated hypotension						INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (the deceased) attended the deceased from Sept. 20, 1966 to July 18, 1967 that (1) (the deceased) last saw the deceased alive on July 17, 1967 and that in (my) (the physician's) opinion death occurred on the date and hour and from the causes stated above. (1) (the deceased) (did not) view the body after death.									
23A. SIGNATURE H.V. Harbold						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 18, 1967	
23C. PHYSICIAN'S NAME (Type) H.V. HARBOLD						23D. ADDRESS 4706 Harford Road Baltimore Maryland 21214			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-21-1967		24C. NAME OF CEMETERY or CREMATORY Slate Ridge		24D. LOCATION (City, town, or county) (State) Delta, York Co., Pa.			
25A. DATE REC'D BY HEALTH DEPT. JUL 24 1967		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR John H. Harbison		ADDRESS Delta, Penn a.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6997				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6997	
M.E. CASE NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) LYNN MARY/SCHRAMM				July 18, 1967 3:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Park Drive				A. STATE W.Va. B. COUNTY			
5. SEX F				6. RACE W			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) (Single) Student				8. DATE OF BIRTH 8/6/52			
9. AGE (In years last birthday) 14				10. CITIZEN OF WHAT COUNTRY? USA			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				11. BIRTHPLACE (State or foreign country) W.Va.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Vernon Schramm			
14. MOTHER'S MAIDEN NAME Erma Davis				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. None				17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary hemorrhage and pneumonia Acute lymphoblastic leukemia				INTERVAL BETWEEN ONSET AND DEATH Terminal 4½ months			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
21. MEDICAL CERTIFICATION							
22. I certify that (I) (this hospital) attended the deceased from Mar. 13 1967 to July 18 1967, that (I) (we) last saw the deceased alive on July 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Henry S. Cröst				23B. DATE SIGNED 7/19/67			
23C. PHYSICIAN'S NAME (Type) Henry S. Cröst, SA Surg (R)				23D. ADDRESS US Public Health Service Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/22/67			
24C. NAME OF CEMETERY OR CREMATORY Potomac Valley Mem. Park				24D. LOCATION (City, town, or county) (State) Keyser, W.Va.			
25A. DATE REC'D BY HEALTH DEPT. JUL 24 1967				25B. NAME OF REGISTRAR Robert E. Farley, MA			
25C. FUNERAL DIRECTOR G. J. Brial				25D. ADDRESS Westernport, Md.			

V
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John Doe

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67-13570 67 6998					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 6998				
1. NAME OF DECEASED (Type or Print) <i>Baby Girl B Charles</i>					2. DATE AND HOUR OF DEATH <i>7-17-67</i> <i>10:30 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>					A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>4893 ALHAMBRA AVE</i>				
					D. STREET ADDRESS (If rural, give location) <i>33d Calvert</i> <i>27-09</i>				
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>NB</i>		8. DATE OF BIRTH <i>7-17-61</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME <i>Marie Charles</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <i>776X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Prematurity</i> DUE TO (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <i>4:30 hours</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>6</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>9-17</i> 19 <i>67</i> to <i>7-17</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9-17</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>[Signature]</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7-17-67</i>		
23C. PHYSICIAN'S NAME (Type) <i>H. L. Rodriguez</i>					23D. ADDRESS <i>ANATOMY DEPARTMENT, BALTIMORE, MARYLAND</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE <i>7-20-67</i>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <i>JOHNS HOPKINS MEDICAL SCHOOL</i>		
25A. DATE RECEIVED BY HEALTH DEPT. <i>JUL 24 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. [Signature]</i>		25C. FUNERAL DIRECTOR ADDRESS <i>MORTUARY SERVICE - BCHD</i>				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 6999	
BIRTH NO. 67-12520 67 6999				CERTIFICATE OF DEATH	
M.E. CASE NO.				Registered No. 67 6999	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Baby boy of Gloria Smith			June 24, 1967		1:30p.m.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217			A. STATE Maryland		
			B. COUNTY G.A. Co.		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Annapolis		
			D. STREET ADDRESS (If rural, give location) 716 1/2 Second Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH June 24, 1967	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 9 35
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Ernest Calvin Philip Smith		
14. MOTHER'S MAIDEN NAME Gloria Delores Butler			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Gloria Smith-mother		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory distress fee - Intubation Anoxia			19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			21. INTERVAL BETWEEN ONSET AND DEATH from birth to 12 hrs after		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 24, 1967 to June 24, 1967 , that (I) (we) last saw the deceased alive on June 24, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel Macardo				23B. DATE SIGNED June 27, 1967	
23C. PHYSICIAN'S NAME (Type) Dr. Manuel Macardo				23D. ADDRESS 1514 Division Street-Baltimore, Maryland, 17	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-14-67		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county)		24E. STATE		24F. FUNERAL DIRECTOR	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farley, MA		25C. ADDRESS	

for. International Bureau
Registration Bureau for the

Handwritten signature

NEW YORK, N.Y.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of city nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 7000				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				Registered No. 67 7000							
M.E. CASE NO.								1. NAME OF DECEASED (Type or Print) <u>Fitzer, Marguerite L</u>								2. DATE AND HOUR OF DEATH <u>7/22/67</u> <u>2:55 p.m.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>324 S. Mount Street</u>								19-04			
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Montebello</u>				(If not in hospital or institution, give street address or location)															
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>		8. DATE OF BIRTH <u>8/20/04</u>		9. AGE (In years last birthday) <u>62</u>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Super markets.</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George T. Fitzer</u>								14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Klear</u>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-72-7573</u>				17. INFORMANT <u>Mrs Baldwin</u> ADDRESS <u>143 S. Montebello Ave</u>											
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>154X + 1 904.1</u> <u>7/24/67</u> <u>Carcinoma - rectal</u>								CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr?</u>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION lost. <u>Fractured R Hip</u>												<u>Dec '65</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>NO</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>324 S. Mount Street</u>											
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>Dec 65</u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR? <u>? - fell.</u>											
22. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> 19 <u>66</u> to <u>7/22</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/22</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <u>Robert W Ireland</u> M.D.								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>7/22/67</u>							
23C. PHYSICIAN'S NAME (Type) <u>Robert W Ireland</u>								23D. ADDRESS M.D. <u>Montebello State Hospital</u>											
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>7-26-67</u>				24C. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>				24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 24 1967</u>				25B. NAME OF REGISTRAR <u>Robert E. Fasham</u>				25C. FUNERAL DIRECTOR <u>GO-L Schwab</u> ADDRESS <u>Francis W. Miller 2101 H. Frederick Ave.</u>											

Montebello State Hospital

Robert W Ireland